Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

Department of Health and Human Services
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Agenda: MaineCare Redesign Task Force

September 12, 2012; 1 – 4 PM
Appropriations and Financial Affairs Committee Room
Statehouse, Room 228

- **Welcome and Introductions**
- **Review of Requested MaineCare Data**
- **Presentation by Michael DeLorenzo, PhD, MaineHealth Management Coalition: Health Care Costs in Maine**
- **Presentation by Elizabeth Mitchell, Executive Director, MaineHealth Management Coalition: Efforts to Impact Healthcare Costs and Performance**
- **Presentation by Dr. Flanigan: MaineCare by the Numbers**
- **Review and Finalize Guiding Principles – Suggested Principles**
    - Cost effective
    - High quality
    - Patient/consumer centered
    - Program Sustainability
    - Holistic and individualized approach based on unique needs
    - Flexibility (not one size fits all)
    - Evidence based
    - Innovation/technical approach
    - Data analytics
    - Collaboration
    - Payer alignment
    - Preventative
    - Medical necessity
- **Future Topics/Agendas**
- **Public Comment**

PART T

Sec. T-1. MaineCare Redesign Task Force established. The Commissioner of Health and Human Services shall establish the MaineCare Redesign Task Force, referred to in this Part as "the task force," to provide detailed information that will enable the Legislature to redesign the MaineCare program in a manner that will maintain high-quality, cost-effective services to populations in need of health coverage, comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010 for state Medicaid programs and realize General Fund savings in fiscal year 2012-13 of $5,250,000.

Sec. T-2. Task force membership. Notwithstanding Joint Rule 353, the task force consists of the Commissioner of Health and Human Services or the commissioner's designee, who serves as chair of the task force, and the following 8 members who are appointed by the commissioner:

1. Two members of the MaineCare Advisory Committee, established pursuant to rule of the Department of Health and Human Services, who represent MaineCare members;

2. Two members of the MaineCare Advisory Committee, established pursuant to rule of the Department of Health and Human Services, who represent providers of MaineCare services;

3. One member of the public who has expertise in public health care policy;

4. One member of the public who has expertise in public health care financing;

5. One member of the public who has expertise in state fiscal policy; and

6. One member of the public who has expertise in economic policy.

Sec. T-3. Convening of task force. The task force shall convene no later than September 1, 2012.

Sec. T-4. Duties. The task force shall undertake a comprehensive review of the MaineCare program established pursuant to the Maine Revised Statutes, Title 22, chapter 855. The task force shall report on the following issues with regard to the MaineCare program:

1. Current eligibility levels, options for eligibility levels and changes to eligibility levels, including any changes that will be required pursuant to the federal Patient Protection and Affordable Care Act of 2010;

2. Current benefits, options for benefits and any changes to benefits, including any changes that will be required pursuant to the federal Patient Protection and Affordable Care Act of 2010;

3. Current premiums, cost-sharing and participation requirements, options for premiums, cost-sharing and participation requirements and any changes to premiums, cost-sharing and participation requirements, including any changes that will be required pursuant to the federal Patient Protection and Affordable Care Act of 2010;

4. The current fiscal status of the MaineCare program, including an analysis of MaineCare spending for the most recent 4 fiscal years and for the current biennium, with spending analysis detail provided by provider type, by eligibility level and by funding source;

5. Current management and administrative strategies and options for management and administrative strategies, including managed care, management of high-cost care and high-cost utilization, prior authorization, accountable care organizations, value-based purchasing and contracted

and in-house administrative services;

6. A review of initiatives being used in other states' Medicaid programs to deliver high-quality services in a manner that is fiscally sustainable and cost-effective; and

7. Recommendations for redesign of the MaineCare program to achieve General Fund savings of $5,250,000 during fiscal year 2012-13 and annually thereafter, including detailed information on any required state plan amendments, applications and amendments to Medicaid waivers and amendments to state law and rule that would be required to implement the redesign and achieve the savings. The recommendations must include draft amendments to state law and rule to implement the redesign of MaineCare.

Sec. T-5. Staffing; consultant services. The Department of Health and Human Services shall provide necessary staffing services to the task force from its personnel. The department may contract for staffing services to supplement the work of departmental personnel. The department shall contract for professional services to research and prepare all necessary Medicaid state plan amendments and waiver applications and amendments that will be required to implement the redesign of MaineCare under section 4 once the redesign is approved by the Legislature under section 7. The contract for professional services must include, after action on the recommendations by the Legislature, final preparation, submission and services necessary to the approval process of all Medicaid state plan amendments and waiver application and amendments.

Sec. T-6. Report. The task force shall report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters as follows.

1. By November 15, 2012, the task force shall report on issues detailed in section 4.

2. By January 1, 2013 and by the first of each month thereafter until final federal action has been completed, the task force shall file information regarding progress in the preparation of the Medicaid state plan amendments and waiver applications and amendments.

Sec. T-7. Implementation; achievement of savings. If, after receipt of the recommendations presented by the task force pursuant to section 6, subsection 1, the Legislature fails to enact legislation in the First Regular Session of the 126th Legislature that achieves $5,250,000 in General Fund savings in fiscal year 2012-13, the Commissioner of Health and Human Services shall make recommendations to the Governor regarding the achievement of the balance of these savings through the use of the temporary curtailment of allotment power specified in the Maine Revised Statutes, Title 5, section 1668, and the Governor is authorized to achieve those savings using that power.

Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Department of Health and Human Services
MaineCare Redesign Task Force Minutes
9/28/2012

Attendance:

Mary C. Mayhew, Commissioner, DHHS
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Jim Clair, Member of the public who has expertise in public health financing
Ryan Low, Member of the public who has expertise in economic policy
Frank Johnson, Member of the public who has expertise in public health care financing
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Scott E. Kemmerer (via the internet), Member of the public who has expertise in public health care policy
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Nick Adolphsen, DHHS, staff
Stefanie Nadeau, DHHS/MaineCare staff
Michelle Probert, DHHS/MaineCare staff
Kevin Flanigan, DHHS/MaineCare staff
Jim Leonard, DHHS/MaineCare Staff
Denise Gilbert, DHHS, staff

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made and the Commissioner provided an overview of the meeting agenda	
Housekeeping	Commissioner informed members that handouts/materials discussed at the meetings will be posted on the DHHS web site at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Minutes will be published on-line and e-mailed to all interested parties. General Public members were encouraged to sign in if they wished to be added to the MaineCare interested parties distribution list. DHHS staff members available in support of the MaineCare Redesign Task Force are: Stefanie Nadeau, Jim Leonard, Nick Adolphsen, and Denise Gilbert. Questions should be forwarded to Nick at Nick.Adolphsen@maine.gov	
Review of Governing Statute	There was a brief review of the Governing Statute – Public Law 2011, Chapter 657, Part T (attached), noting the duties. Members discussed the possibility of working with a facilitator/consultant who has a national health policy perspective. The deadline for the report to the Joint Standing Committees of Appropriations and Financial Affairs and the Health and Human Services is 11/15/12. A draft report should be completed and sent to the DHHS Commissioner's office by 11/6/12 for review.	

Agenda	Discussion	Next Steps
Medicaid Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Stefanie Nadeau presented "An Overview of the MaineCare Program". This outlined MaineCare's contractual relationship with CMS, identified the basic requirements of Medicaid, defined the MaineCare Waiver Populations, numbered MaineCare Enrollment, and provided a brief history of MaineCare Expenditures. Members requested additional information/data: • Section 32 regarding Children • Current caseload information • Chart similar to the "High 5% Service Types – by Net Payments" (Page 22 of the handout) for all populations • Information on co-payment limitations • SPA Waivers: what's available and what are the requirements	The Office of MaineCare Services will provide the requested information at the meeting scheduled on September 12th.
High Cost User Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Dr. Kevin Flanigan presented an overview of "The Top 5%" high cost user. The data indicates that the majority of the cost (approximately 74%) is for non-medical services and a majority of that (approximately 55%) is expended on long term care. An internal committee has been convened to identify and study the high cost user, by doing so the Department hopes to improve the quality of services, eliminate duplication by better coordination of care, thereby cutting costs. The current thinking is for the DHHS to act as its own "Accountable Care Organization" (ACO), across all DHHS programs and clients, matching services (departmental and community based) with identified needs. Questions discussed and additional information requested: • Deeper breakdown of the top 5%, such as age, waiver, etc. • Identify any budget barriers/issues • Criteria used to measure client stability • Define "Care Management" versus "Case Management" • Review of historical patterns by major categories such as pharmacies	The Office of MaineCare Services will provide additional information at the meeting scheduled on September 12th.

Agenda	Discussion	Next Steps
Value Based Purchasing Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Next Michelle Probert presented on DHHS' current initiatives: **MaineCare Value-based Purchasing Strategy**. "In August 2011, Maine DHHS moved away from Managed Care focused principally on cost-containment to leverage on-the-ground initiatives the right care for the right cost". Creating Accountable Communities (ACO) and Health Homes to "improve transitions of care" and "strengthen primary care". The handout identifies the current list of CMS approved conditions for coverage and the newly proposed conditions awaiting CMS approval. Development of the Health Homes is a two stage process. Stage "A" will help individuals with chronic conditions. Timeline for implementation of stage "A" is: 6/12 select eligible health home practices; 7/12 Community Care Team application issued; 9/12 submit state plan amendment; 10/12 Community Care Team selected; 1/13 Stage "A" implemented. Stage "B" will help individuals with SPMI and/or SED. Stage "B" implementation timeline is: 9/12 issue request for information; late Fall 12 initiate discussion with CMS/SAMHSA; Early Winter submit state plan amendment; Spring/Summer implement. It was noted that these initiatives are only financed for 24 months beginning from the date of implementation for each stage. **Emergency Department (Ed) Collaborative Care Management Project**. Objectives are: "to reduce avoidable ED use and improve health outcomes for high needs, high utilizers of the ED through statewide care management efforts by leveraging care management resources in the community" and "identifying and filling gaps where no care management capacity exists" and "increase availability of ED for true emergency situations" building on the successful pilot with MaineGeneral. Suggestions/ideas discussed: - Look at pharmacy model - No need for DHHS Care Managers, providers see DHHS/MaineCare as the information source - This initiative has booked savings of approximately $5.4 million in state and federal funds for previous budgets	Office of MaineCare Services will review pharmacy model and provide information.

Agenda	Discussion	Next Steps
	Accountable Communities Initiative (ACO). According to the DHHS definition and ACO is an entity responsible for population's health and health costs that is "provider-owned and driven", "a structure with strong consumer component and community collaboration" and "includes shared accountability for both cost and quality" featuring two models: Shared Saving Only: minimum 1,000 patients - Share in a maximum of 50% of savings, based on quality performance - Not accountable for any downside risk - Subject to lower per patient cap Shared Savings & Losses: minimum 2,000 patients - Share in a maximum of 60% savings, based on quality performance - Not accountable for any downside risk in the first performance year - In year 2, accountable for up to 5% of any losses - In year 3, accountable for up to 10% of any losses - Must demonstrate capacity for risk sharing Accountable Communities must include all costs for DHHS identified "core" services. Timeline for implementation is: 8/12 start discussions with CMS about State Plan Amendment; 9/12 issue the application; 11/12 send state plan amendment to CMS; 12/12 select accountable communities and 4/13 start the ACOs. Suggestions/Ideas discussed: - Need additional information/follow-up on Section 65 and 28. - Need to discuss global waiver Questions: • Can the savings from DHHS's current initiatives be counted in meeting the goal of the $5 million? No, the savings associated with current initiatives have already been budgeted.	Discuss global waiver at future meeting.

Agenda	Discussion	Next Steps
Guiding Principles	Principles suggested by members: • Cost effective • High quality • Patient/consumer centered • Program Sustainability • Holistic and individualized approach based on unique needs • Flexibility (not one size fits all) • Evidence based • Innovation/technical approach • Data analytics • Collaboration • Payor alignment • Medical necessity	Members can send additional principle suggestions to Nick at Nick.Adolphsen@maine.gov for inclusion. A draft of the principles will be distributed to the task force.
Future Topics/Agendas	Suggestions: • GAP analysis • Review state and private initiatives • Further review of data presented (High Cost, Value based Purchasing) • Limitations by federal regarding incentive and benefit design for flexibility regarding waivers • DRGs	Members will send additional agenda items to Nick. UPCOMING MEETINGS – 1 -4 pm, Rm 228 State House September 12 September 25 October 9 October 23 November 6
Public Comment	Dale Hamilton CHCS asked if the $5 million was per quarter or annually. The $5 million is annual. During the first year the $5 million will have to be absorbed in the last quarter due to the timing of the task force work. Vanessa Santarelli, Maine Primary Care Association, offered to provide any information the Task Force would find helpful. She requested that members be mindful of dental care during the development of health homes. She expressed concern regarding the formal process for public input. Richard Kellogg, TSG spoke about the Independent Home and Community Based services model and offered to provide information to the task force.	Task Force will consider a formal public input process at a future meeting.

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September 12, 2012

To: MaineCare Redesign Task Force Members

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

DHHS is providing responses to inquiries made at the August 28, 2012 MaineCare Redesign Task Force Meeting.

1. What tools are available to help manage Medicaid, i.e. ISPA, waivers, etc.?

   Response: A State Plan is a contract between a state and the Federal government describing how that state administers its Medicaid program. It gives an assurance that a state abides by Federal rules and may claim Federal matching funds for its Medicaid program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative requirements that states must meet to participate.

   States frequently send a state plan amendment, otherwise referred to as a SPA, to the Centers for Medicare and Medicaid Services (CMS) for review and approval. There are many reasons why a state might want to amend their state plan. For example, the state may wish to implement changes required by Federal or state law, Federal or state regulations, or court orders. States also have the flexibility to request permissible program changes, make corrections, or update their plan with new information.

   Under the Social Security Act, several sections allow states to waive government-mandated requirements which pertain to Medicaid under certain circumstances. When a state uses this tool, it is known as a "Medicaid waiver." Medicaid waivers are designed to allow states to be more flexible in providing health care options to their citizens, allowing states to save money and patients to have more freedom of choice. Sections 1115, 1915(b), and 1915(c) all contain specific information about different types of Medicaid waivers and how they work.

   Waivers are tools states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:

   Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.

   Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.

1915(i) State Plan HCBS: State Options

- Target the HCBS benefit to one or more specific populations
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State plan HCBS
- Define the HCBS included in the benefit, including State- defined and CMS-approved "other services" applicable to the population
- Option to allow any or all HCBS to be self-directed

1915 (j) State Options:

- Target people already getting section 1915(c) waiver services
- Limit the number of people who will self-direct their PAS
- Limit the self-direction option to certain areas of the state, or offer it Statewide

1915 (k) Community First Choice State Plan Option

The "Community First Choice Option" lets states provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan.

This option became available on October 1, 2011 and provides a 6 % increase in Federal matching payments to States for expenditures related to this option.

Sources:
http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

2. What are the Federal co-payment requirements?

   Response: Please see **Attachment A**

3. Please provide Dr. Brenner's Hot Spotters article as well as the data pulled for Maine.

   Response: Please see **Attachment B**

4. What are other states doing for cost containment measures?

   Response: Please see **Attachment C**

5. What are other states doing in regard to Medicaid changes? What are policy think tanks in other states publishing that may be of assistance?

   Response: Please see **Attachment D**. This report is not all inclusive. Other information will be provided on this topic at a later date.

6. What is the historical spending in Medicaid?

   Response: Please see **Attachment E**

7. Please provide data on the growth of enrollment in Medicaid.

   Response: Please see **Attachment F**

Attachment A

Co-Payment Requirements

Copayments

Federal Allowable Copayment Amounts

State Payment for Services	FY 2012 Maximum Copayment
$10.00 or less	$0.65
$10.01 - $25.00	$1.30
$25.01 - $50.00	$2.55
$50.01 – more	$3.80

Maine Current Copayment Amounts

When MaineCare pays . . .	the member co-payment is
$10.00 or less	$0.50
$10.01 - $25.00	$1.00
$25.01 - $50.00	$2.00
$50.01 – more	$3.00

Current MaineCare Service Copayment Amounts

Non-Emergency Service *	Co-payments	
	Per day max	Per month max
Ambulance	$3.00	$30.00
Chiropractor	$2.00	$20.00
Consumer Directed Attendant	$3.00	$5.00
Durable Medical Equipment	$3.00	$30.00
Federally Qualified Health Centers	$3.00	$30.00
Home Health Services	$3.00	$30.00
Hospital (inpatient and/or outpatient)**	$3.00	$30.00
Laboratory	$1.00	$10.00
Occupational Therapy	$2.00	$30.00
Opticians	$2.00	$20.00
Optometrists	$3.00	$30.00
Physical Therapy	$2.00	$20.00
Podiatrist	$2.00	$20.00
Prescription Drugs ***	$3.00/ prescription	$30.00
Private Duty Nursing	$3.00	$5.00
Rural Health Center	$3.00	$30.00
Speech	$2.00	$20.00
Behavioral Health Services	$2.00	$20.00

Federal Maximum Allowable Copayments

Services and Supplies	Eligible Populations by Family Income <100% FPL	101-150% FPL	>150% FPL
Institutional Care (inpatient hospital care, rehab care, etc.)	50% of cost for 1st day of care	50% of cost for 1st day of care or 10% of cost	50% of cost for 1st day of care or 20% of cost
Non-Institutional Care (physician visits, physical therapy, etc.)	$3.80	10% of costs	20% of costs
Non-emergency use of the ER	$3.80	$7.60	No limit
Drugs Preferred drugs Non-preferred drugs	 $3.80 $3.80	 $3.80 $3.80	 $3.80 20% of cost

Other Considerations

*State Plan and/or Waiver Amendments are required for any changes to the current levels of cost sharing and premium amounts charged.

*The combination of premiums and cost-sharing must not exceed 5% of the members monthly or quarterly income. Determination of monthly vs. quarterly income is determined by the State.

*All children under the age of 18 with income below 133% FPL will become exempt from cost sharing and premium requirements pursuant to the ACA.

*The State may terminate eligibility for Medicaid because of failure to pay a premium, however, the termination cannot occur until the failure to pay such premium has continued for a period of 60 days or more. A State may also waive payment of premium in any case where it determines that requiring the payment would create an undue hardship.

*The State may permit a provider to require as a condition of the covered care, items or services to a Medicaid-eligible individual, the individual to pay the cost sharing amount. A State Plan Amendment is required.

*The State may not impose cost sharing for emergency room services (excluding non-emergency services), hospice, family planning and preventative services provided to children under 18 years of age, regardless of family income. All preventative services a state chooses to cover will become exempt eff. 1/1/13, pursuant to the ACA.

*States have the option to impose higher, alternative premiums on other groups of enrollees, if their family incomes exceed 150% of the federal poverty level. Certain groups, such as institutionalized individuals and most children are excluded from higher cost sharing.

*States may exempt additional groups of individuals from premiums or additional items or services from cost sharing. States also may further reduce the premiums and cost sharing below the limitations specified by the law.

Attachment B, 1&2

"Hot Spotters" and Related Maine Data

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec, and Penobscot Counties, FY2009 & FY2010

About the Project

The Camden Coalition of Healthcare Providers (CCHP) is an nine-year old strategic initiative with a mission to improve the quality, capacity, and accessibility of the healthcare system for vulnerable populations in the City of Camden. The Camden Coalition of Healthcare Providers has compiled the Camden Health Database, a citywide all-payor, all-provider claims database that contains data on all hospital encounters from 2002 through 2010. The Camden Health Database has shown to be a tremendous tool for quantifying and analyzing local health trends. Using its expertise in managing and analyzing claims data, CCHP has analyzed 2 years of Medicaid claims data from the MaineCare database. Data was extracted for three counties (Cumberland, Kennebec, and Penobscot) for the 2009 and 2010 fiscal years.

Summary of Findings

For the study area in 2009, MaineCare payed $123.7 million for 73,821 ED visits and 12,877 Inpatient (IP) visits made by 38,485 unique patients. For the study area in 2010, MaineCare payed $136.8 million for 78,723 ED visits and 12,880 Inpatient visits made by 41,339 unique patients.

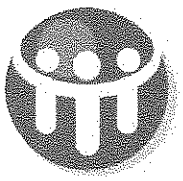
614 (1%) of patients accounted for 31.6% of total hospital costs during the 2 year period ; 12,228 (20%) patients accounted for 87% of costs during the 2 year period.

High utilizer patients are defined as those patients with 6 or more ED visits and/or 3 or more IP visits during the 2 year time period. 6,121 patients (9.9%) met this "High Utilizer" definition. While High Utilizer's represented less than 10% of all MaineCare patients they accounted for 46% of all hospital costs.

Inpatient High Utilizers
The three most prevalent inpatient diagnosis for High Utilizers were "alcohol-related disorders", "mood disorders", and "chronic obstructive pulmonary disease and bronchiectasis". Inpatient High Utilizers are 2.12 times more likely to have an Inpatient stay with a diagnosis of "alcohol-related disorders" compared to non-High Utilizers, 1.97 times more likely to have an inpatient stay with a diagnosis of "chronic obstructive pulmonary disease and bronchiectasis", and 1.81 times more likely to have a diagnosis of "diabetes" compared to non-High Utilizers. 72% of all IP High Utilizers were over age 34

ED High Utilizers
The three most prevalent emergency department diagnosis for High Utilizers were "sprains and strains", "disorders of teeth and jaw", and "other upper respiratory infections". ED High Utilizers are 1.46 times more likely to have an ED visit with a diagnosis of "anxiety disorders" compared to non-High Utilizers, 1.46 times more likely to have an ED visit with a diagnosis of "spondylosis; intervertebral disc disorders; other back problems", and 1.38 times more likely to have a diagnosis of "Headache; including migraine". 67% of all ED High Utilizers were under age 35

Portland (993), Bangor (462), Waterville (426) and Augusta (357) had the highest prevalence of High Utilizer patients. Together, these four towns contain 46% of all high utilizers. Of all towns with at least 200 MaineCare members, Waterville (14.95%), Lincoln (12.78%), and Winslow (12.25%) had the highest rate of High Utilizers.



Camden Coalition of Healthcare Providers
www.camdenhealth.org

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties: 7/1/2008 - 6/30/2010

Total Patients, Visits, and Costs*, ED and Inpatient

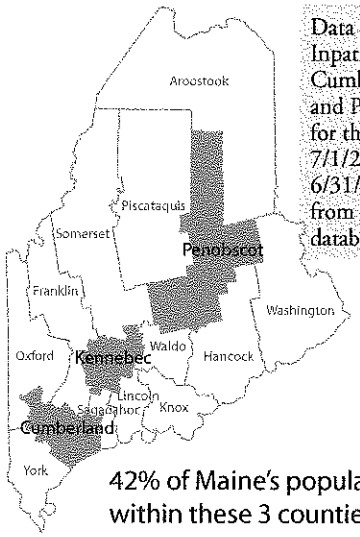
Emergency Room

Year	Patients	Visits	Charged	Allowed	Paid
FY09	35,270	73,821	$63,973,283	$47,651,409	$25,681,140
FY10	37,931	78,723	$72,429,885	$54,342,377	$30,072,805

Inpatient

Year	Patients	Visits	Charged	Allowed	Paid
FY09	7,310	12,877	$167,713,214	$152,870,768	$98,025,526
FY10	7,691	12,880	$186,698,504	$168,151,559	$106,692,703

Fiscal years (FYs) begin 7/1 and ends 6/30



42% of Maine's population lives within these 3 counties

Data Source: All ED and Inpatient claims for Cumberland, Kennebec, and Penobscot counties for the period beginning 7/1/2008 and ending 6/31/2010, extracted from the MaineCare State database.

Concentration of Total ED and Inpatient Costs*

Top % by cost	Patients	Total Paid (in millions) Amount	Percent	Inpatient Visits	Percent	Emergency Department Visits	Percent
1 percent	614	$82.2	31.6%	3,260	15.3%	4,951	3.3%
5 percent	3,069	$154.7	59.4%	8,765	41.1%	17,552	11.7%
10 percent	6,138	$190.9	73.3%	12,578	59.0%	29,925	19.9%
20 percent	12,276	$226.5	86.9%	17,980	84.3%	49,415	32.8%
30 percent	18,414	$240.6	92.4%	19,627	92.0%	74,839	49.7%
40 percent	24,552	$247.4	95.0%	19,894	93.3%	94,249	62.6%
60 percent	36,828	$255.0	97.9%	20,189	94.7%	119,857	79.6%
80 percent	49,104	$258.9	99.4%	20,397	95.6%	136,402	90.6%
100 percent	61,380	$260.5	100.0%	21,327	100.0%	150,492	100.0%

20% of patients account for 86.9% of costs

Distribution of ED & Inpatient Visits

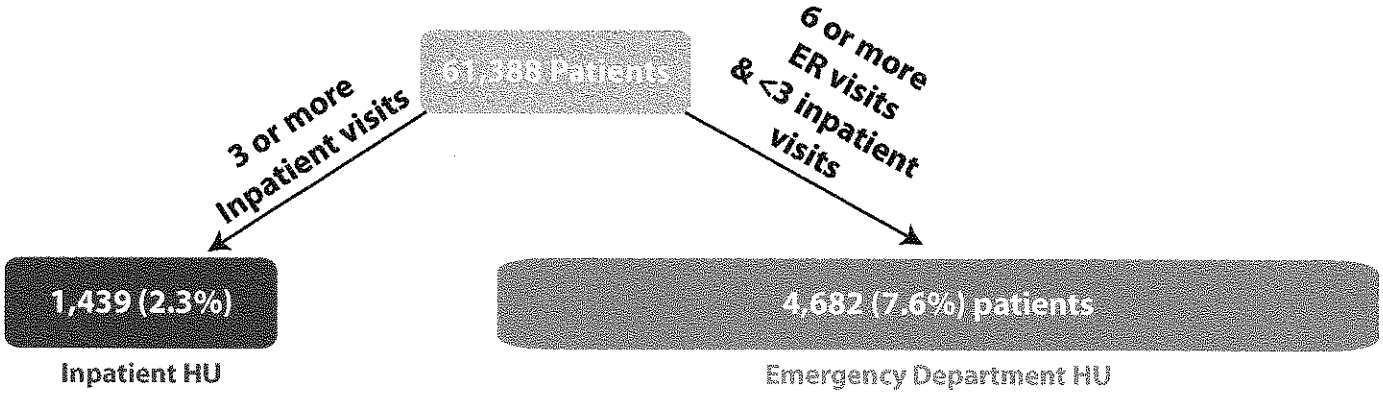
	Inpatient Visits	Patients	Percent	Total Paid (in millions)	per Patient
	1	10,190	74.6%	$80.6	$7,912
	2	2,038	14.9%	$39.8	$19,507
High Utilizers	3-5	1,136	8.3%	$48.1	$42,299
High Utilizers	6-10	248	1.8%	$27.0	$108,704
High Utilizers	11-20	51	0.4%	$8.0	$157,319
High Utilizers	>20	4	0.0%	$1.3	$324,204
	All	13,667		$204.7	$14,979
	High Utilizers	1,439	10.5%	$84.3	$58,605

	Emergency Department Visits	Count	Percent	Total Paid (in millions)	Per Patient
	1	26,504	46.8%	$9.5	$358
	2-3	19,095	33.7%	$15.7	$823
	4-5	5,914	10.4%	$9.2	$1,551
High Utilizers	6-10	3,805	6.7%	$10.6	$2,783
High Utilizers	11-25	819	1.4%	$4.1	$5,006
High Utilizers	26-50	265	0.5%	$2.1	$7,673
High Utilizers	51-100	100	0.2%	$1.0	$10,329
High Utilizers	100-200	144	0.3%	$2.2	$15,089
High Utilizers	>200	35	0.1%	$1.0	$28,890
	All	56,687		$55.8	$983
	High Utilizers	5,168	9.1%	$20.9	$4,134

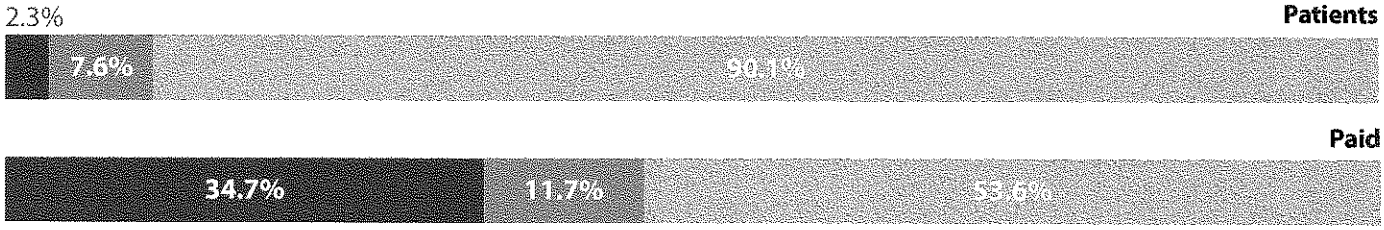
*Costs throughout this report reflect claim payments and do not consider any off-claim settlements or adjustments. General acute hospital payments are estimated based on a proportion (cost to charge ratio) of the allowed amount on the claim.

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

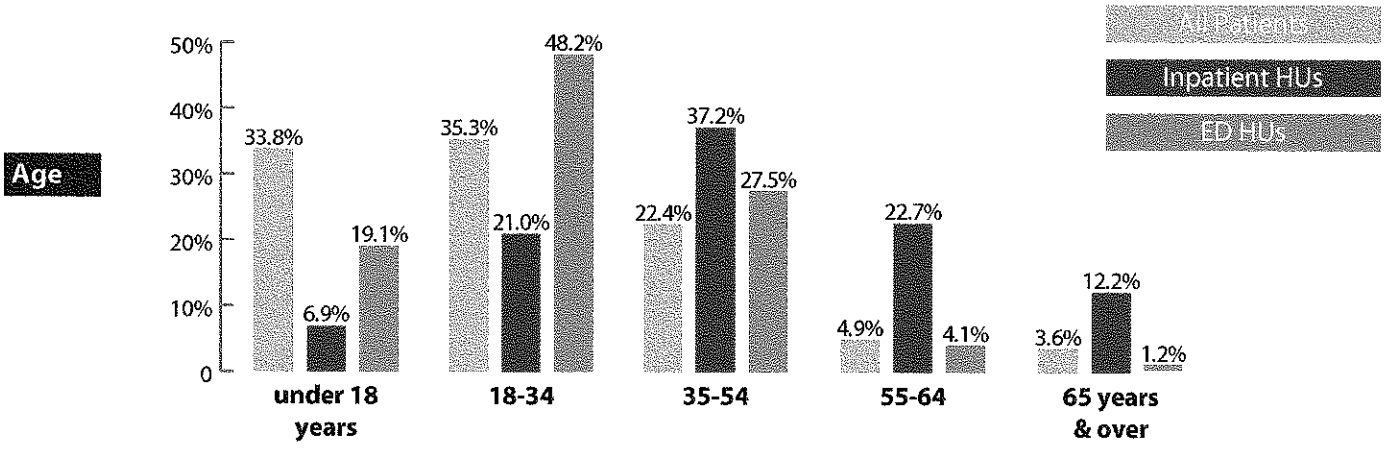
How we define a High Utilizer

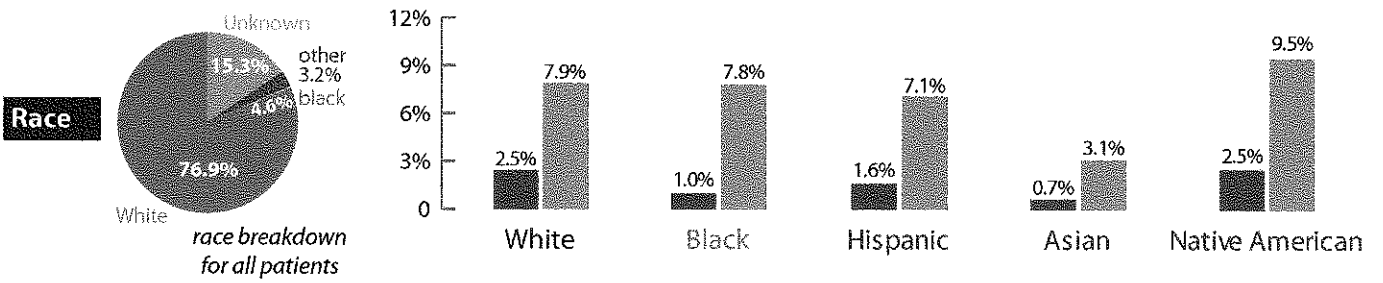


High Utilizers as a percentage of all patients and costs



Demographic profile of patients





MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

Cumberland, Kennebec and Penobscot MaineCare patients by inpatient and emergency visits, FY09 – FY10			
Emergency Department Visits	Inpatient Visits		
	0 - 1	2	3 or more
0 to 3	**Normal Utilization Range** Patients: 39,246 (79%) Total ED amount paid: $19.5 million (44%) Avg ED amount paid per visit: $348 Total IP amount paid: $56.6 million (33%) Avg IP amount paid per visit: $7,911	**Potential High INP Utilizers** Patients: 1,335 (3%) Total ED amount paid $1.0 million (2%) Avg ED amount paid per visit: $490 Total IP amount paid $26.1 million (16%) Avg IP amount paid per visit: $9,790	**High Inpatient Utilizers** Patients: 1,132 (2%) Total ED amount paid $4.5 million (10%) Avg ED amount paid per visit: $588 Total IP amount paid $66.0 million (41%) Avg IP amount paid per visit: $12,616
4 to 5	**Potential High ED Utilizers** Patients: 4,425 (9%) Total ED amount paid: $6.6 million (15%) Avg ED amount paid per visit: $341 Total IP amount paid: $5.0 million (3%) Avg IP amount paid per visit: $6,783		
6 or more	**High ED Utilizers** Patients: 3,422 (7%) Total ED amount paid: $11.5 million (26%) Avg ED amount paid per visit: $363 Total IP amount paid: $6.2 million (4%) Avg IP amount paid per visit: $7,698	**High ED Utilizers** Potential High INP Patients: 326 (1%) Total ED amount paid $1.7 million (4%) Avg ED amount paid per visit: $463 Total IP amount paid: $4.8 million (3%) Avg IP amount paid per visit: $7,380	

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

Most Prevalent High Utilizer ED Diagnoses

Rank	Primary Diagnosis	High Utilizer Incidence	Total Incidence	odds ratio
1	Sprains and strains	2,672	8,408	1.08
2	Disorders of teeth and jaw	2,604	6,658	1.34
3	other upper respiratory infections	2,556	10,381	0.82
4	Superficial injury; contusion	2,535	9,080	0.94
5	Abdominal pain	2,472	6,897	1.22
6	Spondylosis; intervertebral disc disorders; other back problems	1,855	4,347	1.46
7	Headache; including migraine	1,279	3,149	1.38
8	Skin and subcutaneous tissue infections	1,180	3,476	1.15
9	Mood disorders	1,168	3,101	1.28
10	Otitis media and related conditions	1,068	4,865	0.73
11	Other connective tissue disease	971	2,832	1.16
12	Other nervous system disorders	929	2,311	1.36
13	Urinary Tract Infection	870	2,793	1.05
14	Other non-traumatic joint disorders	801	2,138	1.27
15	Nonspecific chest pain	792	2,959	0.90
16	Nausea and vomiting	782	2,629	1.00
17	Anxiety disorders	765	1,780	1.46
18	Other complications of pregnancy	727	2,270	1.08
19	Asthma	709	2,224	1.08
20	Other lower respiratory disease	698	2,596	0.91

Most Prevalent High Utilizer Inpatient Diagnoses

Rank	Primary Diagnosis	High Utilizer Incidence	Total Incidence	odds ratio
1	Alcohol-related disorders	593	914	2.12
2	Mood disorders	256	746	1.07
3	Chronic obstructive pulmonary disease and bronchiectasis	239	392	1.94
4	Pneumonia	185	538	1.08
5	Complication of device; implant or graft	179	296	1.91
6	Complications of surgical procedures or medical	175	339	1.63
7	Nonspecific chest pain	174	367	1.49
8	Substance-related disorders	174	680	0.79
9	Diabetes	171	299	1.81
10	Pancreatic disorders (not diabetes)	158	292	1.71
11	Septicemia (except in labor)	155	346	1.41
12	Rehabilitation care; fitting of prostheses; and	145	253	1.81
13	Respiratory failure; insufficiency; arrest (adult)	140	233	1.89
14	Maintenance chemotherapy; radiotherapy	130	143	2.87
15	Congestive heart failure; nonhypertensive	123	220	1.76
16	Fluid and electrolyte disorders	117	247	1.49
17	Other complications of pregnancy	115	608	0.58
18	Coronary atherosclerosis and other heart disease	112	238	1.48
19	Skin and subcutaneous tissue infections	111	356	0.97
20	Schizophrenia and other psychotic disorders	107	263	1.27

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

ED diagnoses for all individuals under 18 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Other upper respiratory infections	4,390	5,368	$2,418,647	$1,128,656
Otitis media and related conditions	3,018	3,796	$1,610,963	$806,380
Superficial injury; contusion	2,927	3,289	$1,689,790	$689,227
Fever of unknown origin	1,730	2,011	$1,198,701	$552,812
Viral Infection	1,526	1,673	$774,510	$342,159
Open wounds of head; neck; and trunk	1,511	1,630	$1,065,351	$556,887
Sprains and strains	1,387	1,601	$1,000,689	$388,633
Other injuries and conditions due to external causes	1,278	1,368	$935,037	$390,978
Allergic reactions	1,103	1,215	$467,479	$244,624
Nausea and vomiting	976	1,094	$602,589	$294,256
Open wounds of extremities	1,025	1,086	$723,160	$365,145
Abdominal pain	899	1,057	$1,239,219	$417,107
Fracture of upper limb	855	914	$1,106,261	$501,458
Other lower respiratory disease	758	805	$459,724	$225,815
Asthma	624	792	$608,546	$297,042
Inflammation; infection of eye (except that caused by tuberculosis)	634	671	$234,941	$120,414
Other ear and sense organ disorders	595	645	$240,129	$123,289
Skin and subcutaneous tissue infections	548	637	$338,613	$163,241
Pneumonia	550	614	$573,171	$239,203
Other skin disorders	566	601	$210,073	$107,325
Other gastrointestinal disorders	502	550	$338,141	$138,201
Noninfectious gastroenteritis	523	547	$346,004	$149,354
Attention-deficit, conduct, and disruptive behavior disorders	365	546	$382,679	$196,561
Urinary Tract Infection	417	480	$351,113	$136,843
Influenza	459	476	$262,782	$118,703
Acute bronchitis	431	468	$357,120	$165,635

Inpatient diagnoses for all individuals under 18 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Pneumonia	141	179	$1,424,997	$855,393
Acute bronchitis	129	156	$1,310,839	$771,710
Asthma	104	146	$708,316	$416,705
Liveborn	67	93	$3,760,772	$2,198,113
Fluid and electrolyte disorders	71	87	$381,808	$226,747
Epilepsy; convulsions	68	86	$902,186	$542,781
Maintenance chemotherapy; radiotherapy	17	82	$982,609	$571,205
Appendicitis and other appendiceal conditions	54	69	$970,338	$601,638
Complication of device; implant or graft	38	69	$1,759,369	$1,026,929
Mood disorders	50	64	$1,005,412	$648,639
Other upper respiratory infections	50	58	$280,446	$165,777
Skin and subcutaneous tissue infections	49	55	$458,521	$277,133
Cardiac and circulatory congenital anomalies	33	53	$2,731,951	$1,608,390
Urinary Tract Infection	35	52	$280,689	$168,015
Other perinatal conditions	39	48	$850,821	$484,688
Fever of unknown origin	36	43	$583,191	$342,886
Other gastrointestinal disorders	27	40	$682,227	$404,202
Complications of surgical procedures or medical	29	40	$897,834	$516,658

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

ED diagnoses for all individuals 18 - 49 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Sprains and strains	4,799	6,150	$4,400,980	$1,708,166
Disorders of teeth and jaw	3,593	6,005	$2,865,540	$1,474,033
Abdominal pain	3,482	5,200	$8,962,659	$2,821,222
Superficial injury; contusion	3,953	5,013	$4,059,488	$1,444,951
Other upper respiratory infections	3,819	4,639	$2,365,519	$1,056,093
Spondylosis; intervertebral disc disorders; other back problems	2,450	3,489	$2,531,268	$1,093,021
Headache; including migraine	1,783	2,581	$2,940,309	$1,201,590
Skin and subcutaneous tissue infections	1,641	2,444	$1,812,431	$847,147
Mood disorders	1,445	2,408	$2,427,834	$1,119,714
Other complications of pregnancy	1,562	2,300	$2,162,912	$1,007,451
Urinary Tract Infection	1,658	2,055	$2,026,096	$728,675
Other connective tissue disease	1,708	2,047	$1,313,468	$559,828
Open wounds of extremities	1,777	2,033	$1,718,766	$839,857
Nonspecific chest pain	1,447	1,948	$3,760,319	$1,520,138
Other nervous system disorders	1,435	1,845	$1,550,292	$609,043
Other non-traumatic joint disorders	1,236	1,495	$949,001	$398,175
Other injuries and conditions due to external causes	1,317	1,460	$1,510,803	$559,576
Anxiety disorders	1,017	1,389	$1,114,052	$505,725
Nausea and vomiting	1,080	1,370	$1,587,187	$662,348
Other lower respiratory disease	1,215	1,369	$1,431,947	$551,832
Chronic obstructive pulmonary disease and bronchiectasis	1,152	1,289	$1,006,907	$420,142
Asthma	889	1,219	$1,069,547	$489,771
Allergic reactions	1,024	1,194	$644,506	$321,939
Alcohol-related disorders	606	1,165	$1,575,459	$658,034
Viral Infection	1,016	1,082	$739,802	$294,090
Open wounds of head; neck; and trunk	914	1,029	$1,041,280	$446,792
Otitis media and related conditions	921	1,027	452,629	223,447

Inpatient diagnoses for all individuals 18 - 49 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
OB-related trauma to perineum and vulva	988	1,122	$6,615,152	$4,245,861
Other complications of birth; puerperium affecting	647	780	$6,674,315	$4,138,255
Other complications of pregnancy	558	715	$4,864,503	$2,969,565
Substance-related disorders	520	696	$4,298,701	$2,993,821
Alcohol-related disorders	283	658	$3,692,344	$2,659,478
Mood disorders	415	614	$5,967,122	$3,773,585
Previous C-section	488	595	$6,368,049	$3,940,177
Prolonged pregnancy	459	522	$4,212,755	$2,611,158
Normal pregnancy and/or delivery	339	378	$1,708,417	$1,052,137
Polyhydramnios and other problems of amniotic	296	339	$3,158,203	$1,913,253
Fetal distress and abnormal forces of labor	263	305	$2,701,620	$1,701,147
Hypertension complicating pregnancy; childbirth and the	245	295	$3,375,659	$2,072,074
Early or threatened labor	216	279	$1,973,410	$1,190,771
Malposition; malpresentation	204	237	$2,596,037	$1,600,724
Skin and subcutaneous tissue infections	170	235	$2,270,454	$1,428,629
Pancreatic disorders (not diabetes)	118	223	$2,782,116	$1,650,512
Diabetes	82	217	$2,109,560	$1,272,322
Pneumonia	145	200	$2,887,179	$1,839,766
Nonspecific chest pain	115	197	$1,533,994	$971,080
Poisoning by other medications and drugs	115	187	$1,388,190	$887,053
Umbilical cord complication	167	183	$1,111,741	$690,508
Schizophrenia and other psychotic disorders	98	179	$1,677,082	$1,104,207

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

ED diagnoses for all individuals 50 years and older

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Nonspecific chest pain	662	967	$2,309,369	$895,309
Superficial injury; contusion	722	875	$759,063	$250,877
Abdominal pain	542	802	$1,563,138	$441,915
Spondylosis; intervertebral disc disorders; other back problems	533	776	$534,284	$213,568
Sprains and strains	595	745	$601,735	$219,601
Alcohol-related disorders	242	743	$964,570	$398,957
Chronic obstructive pulmonary disease and bronchiectasis	468	728	$916,217	$338,471
Other connective tissue disease	447	530	$395,631	$148,258
Disorders of teeth and jaw	346	480	$217,815	$110,669
Skin and subcutaneous tissue infections	333	469	$379,231	$156,278
Other lower respiratory disease	389	464	$572,870	$205,800
Other upper respiratory infections	375	456	$267,276	$102,372
Other nervous system disorders	330	422	$474,965	$171,989
Other non-traumatic joint disorders	327	407	$268,303	$101,825
Mood disorders	251	389	$407,067	$173,054
Headache; including migraine	241	366	$411,279	$158,360
Anxiety disorders	186	308	$216,013	$94,999
Open wounds of extremities	275	304	$227,410	$98,957
Urinary Tract Infection	226	294	$305,534	$91,883
Other injuries and conditions due to external causes	260	282	$368,570	$124,339
Asthma	154	249	$255,132	$112,481
Residual codes; unclassified	212	239	$297,140	$95,812
Nausea and vomiting	190	229	$297,907	$103,682
Conditions associated with dizziness or vertigo	191	227	$291,753	$93,501
Pneumonia	194	218	$310,206	$115,636

Inpatient diagnoses for all individuals 50 years and older

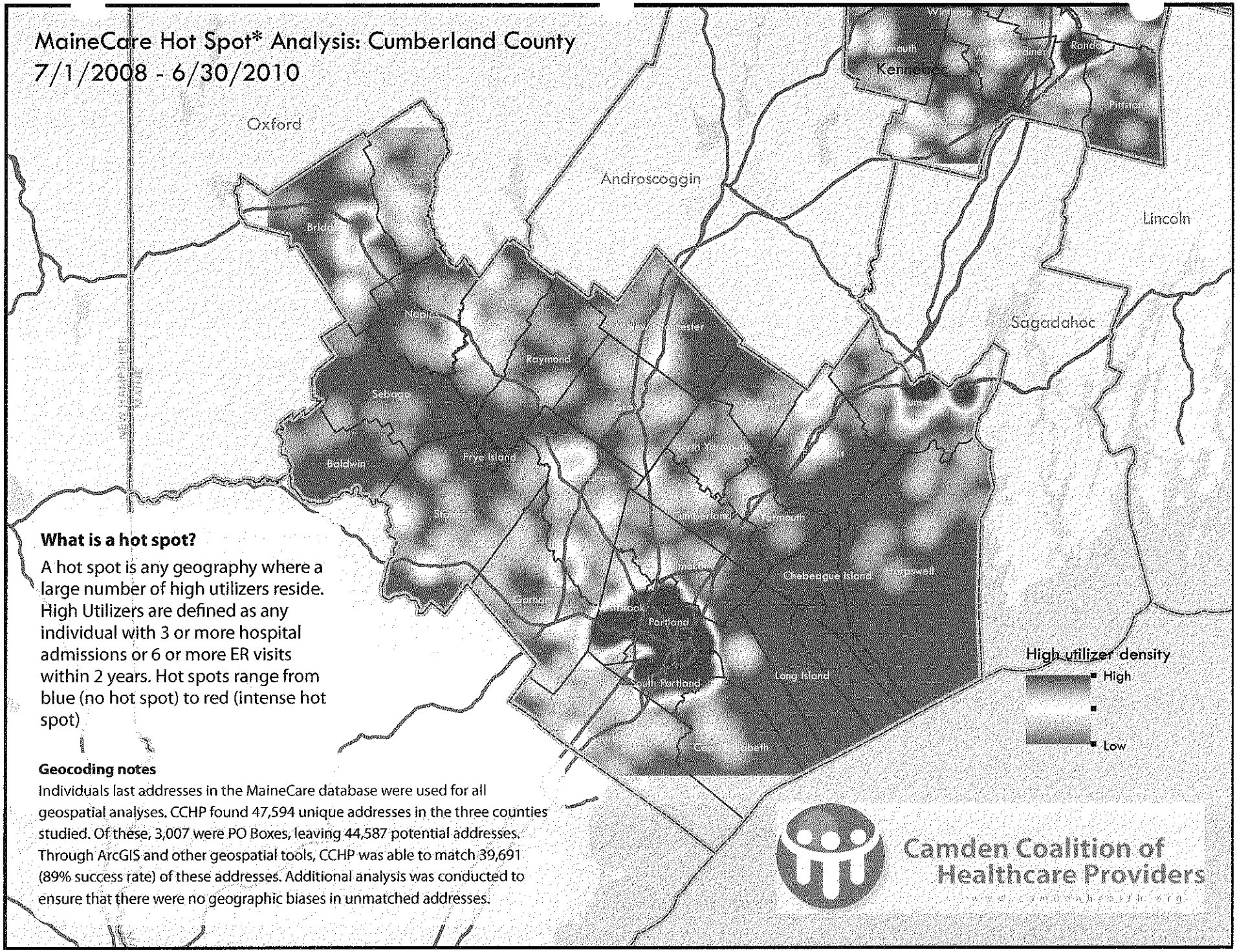
Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Chronic obstructive pulmonary disease and bronchiectasis	221	478	$4,216,411	$2,151,327
Alcohol-related disorders	175	416	$2,920,169	$2,042,556
Respiratory failure; insufficiency; arrest (adult)	112	294	$4,400,332	$2,396,912
Septicemia (except in labor)	172	292	$7,720,849	$4,377,668
Pneumonia	185	282	$3,021,937	$1,594,784
Nonspecific chest pain	168	250	$1,733,547	$1,029,170
Congestive heart failure; nonhypertensive	134	221	$2,935,058	$1,298,613
Coronary atherosclerosis and other heart disease	153	219	$5,457,305	$2,927,829
Acute myocardial infarction (AMI)	136	212	$4,042,676	$2,110,939
Rehabilitation care; fitting of prostheses; and	160	209	$4,032,899	$2,244,709
Mood disorders	117	194	$2,977,767	$1,677,150
Complications of surgical procedures or medical	122	177	$3,877,685	$2,121,142
Osteoarthritis	127	171	$4,250,454	$2,394,620
Schizophrenia and other psychotic disorders	71	164	$1,810,266	$951,985
Cardiac dysrhythmias	107	160	$1,920,202	$966,771
Complication of device; implant or graft	89	142	$4,002,734	$1,855,960
Skin and subcutaneous tissue infections	88	138	$1,690,728	$974,123
Acute cerebrovascular disease	94	128	$3,179,557	$1,468,345
Pancreatic disorders (not diabetes)	56	123	$1,618,950	$931,599
Acute and unspecified renal failure	85	122	$1,376,749	$613,959
Diabetes	80	122	$1,760,447	$950,450
Fluid and electrolyte disorders	86	115	$695,339	$432,150
Secondary malignancies	56	111	$1,707,931	$916,477
Urinary Tract Infection	65	104	$1,077,308	$441,643

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

Geographies

Town	Total members that reside in town	# of inp visits from residents of town	# of ED visits from residents of town	# of High Utilizers that are residents of town	Percent of town's members that are High Utilizers	This town has what percentage of all members	This town has what percentage of all High Utilizers	This town has what percentage of all inpatient visits	This town haas what percentage of all ER visits
Enfield	129	28	371	20	15.50%	0.26%	0.41%	0.17%	0.31%
Waterville	2,849	834	8,957	426	14.95%	5.71%	8.73%	4.94%	7.43%
Veazie	97	37	241	14	14.43%	0.19%	0.29%	0.22%	0.20%
Lagrange	97	20	243	13	13.40%	0.19%	0.27%	0.12%	0.20%
Lincoln	947	256	2,648	121	12.78%	1.90%	2.48%	1.52%	2.20%
Winslow	939	286	2,473	115	12.25%	1.88%	2.36%	1.70%	2.05%
Newport	471	133	1,310	57	12.10%	0.94%	1.17%	0.79%	1.09%
Clifton	109	34	235	13	11.93%	0.22%	0.27%	0.20%	0.20%
Portland	8,360	3,007	23,728	993	11.88%	16.76%	20.35%	17.82%	19.69%
Pownal	59	18	124	7	11.86%	0.12%	0.14%	0.11%	0.10%
Brunswick	1,481	674	3,654	175	11.82%	2.97%	3.59%	3.99%	3.03%
Plymouth	195	39	540	23	11.79%	0.39%	0.47%	0.23%	0.45%
Alton	85	39	232	10	11.76%	0.17%	0.20%	0.23%	0.19%
Benton	391	114	973	46	11.76%	0.78%	0.94%	0.68%	0.81%
Oakland	786	195	2,089	92	11.70%	1.58%	1.89%	1.16%	1.73%
Millinocket	712	178	1,898	83	11.66%	1.43%	1.70%	1.05%	1.57%
Bradley	88	26	232	10	11.36%	0.18%	0.20%	0.15%	0.19%
Medway	108	34	271	12	11.11%	0.22%	0.25%	0.20%	0.22%
Augusta	3,237	1,158	8,235	357	11.03%	6.49%	7.32%	6.86%	6.83%
Clinton	399	113	1,052	44	11.03%	0.80%	0.90%	0.67%	0.87%
Casco	328	100	758	36	10.98%	0.66%	0.74%	0.59%	0.63%
Bangor	4,490	1,721	11,084	462	10.29%	9.00%	9.47%	10.20%	9.20%
Vassalboro	391	102	983	40	10.23%	0.78%	0.82%	0.60%	0.82%
Bridgton	560	182	1,331	57	10.18%	1.12%	1.17%	1.08%	1.10%
Chester	69	22	183	7	10.14%	0.14%	0.14%	0.13%	0.15%
Dexter	783	214	1,941	78	9.96%	1.57%	1.60%	1.27%	1.61%
Sidney	373	97	866	37	9.92%	0.75%	0.76%	0.57%	0.72%
Belgrade	215	74	539	21	9.77%	0.43%	0.43%	0.44%	0.45%
Randolph	270	94	659	26	9.63%	0.54%	0.53%	0.56%	0.55%
Exeter	105	37	225	10	9.52%	0.21%	0.20%	0.22%	0.19%
North Yarmouth	107	26	272	10	9.35%	0.21%	0.20%	0.15%	0.23%
Corinth	325	112	727	30	9.23%	0.65%	0.61%	0.66%	0.60%
Etna	168	63	434	15	8.93%	0.34%	0.31%	0.37%	0.36%
Cumberland	125	52	234	11	8.80%	0.25%	0.23%	0.31%	0.19%
East Millinocket	311	71	766	27	8.68%	0.62%	0.55%	0.42%	0.64%
Brewer	854	351	1,983	74	8.67%	1.71%	1.52%	2.08%	1.65%
Harpswell	188	69	403	16	8.51%	0.38%	0.33%	0.41%	0.33%
Westbrook	1,775	690	3,890	151	8.51%	3.56%	3.09%	4.09%	3.23%
Freeport	356	142	706	30	8.43%	0.71%	0.61%	0.84%	0.59%
Winthrop	460	188	900	38	8.26%	0.92%	0.78%	1.11%	0.75%
South Portland	2,027	604	4,590	167	8.24%	4.06%	3.42%	3.58%	3.81%
other towns	13,705	4,499	26,704	866	6.32%	21.6%	15.07%	21.05%	18.14%
All Geographies	**49,886**	**16,873**	**120,515**	**4,880**	**9.78%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

MaineCare Hot Spot* Analysis: Cumberland County
7/1/2008 - 6/30/2010



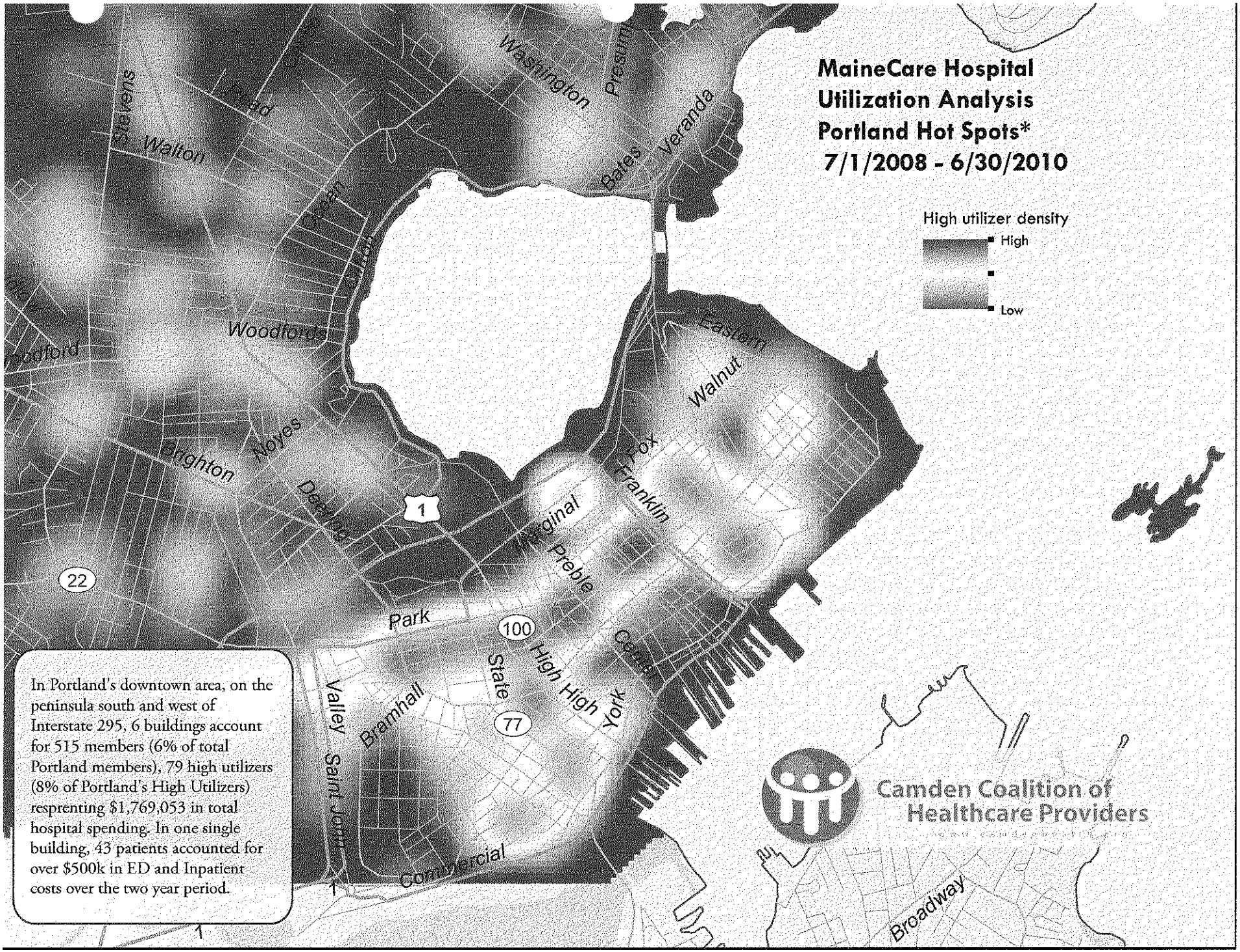
What is a hot spot?

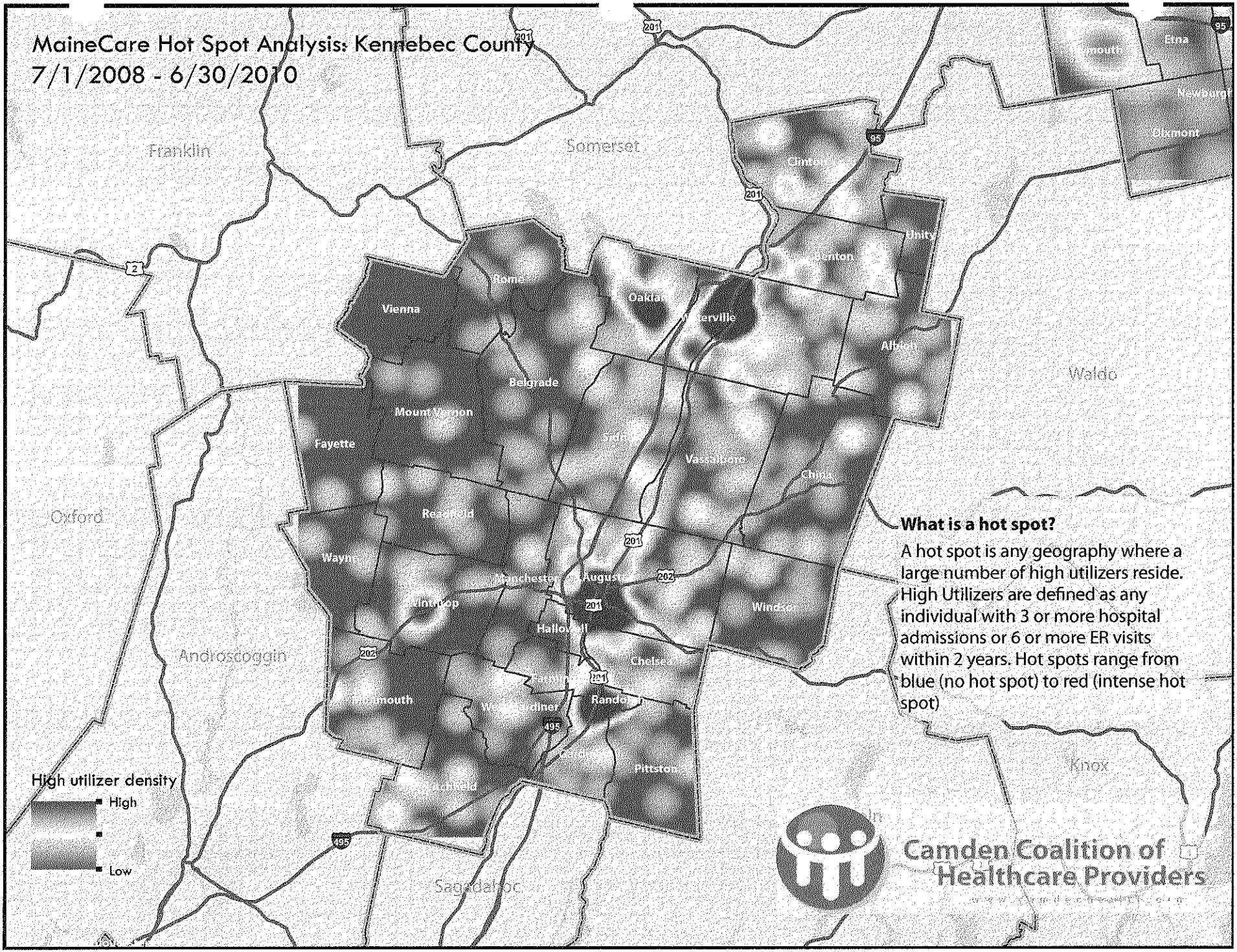
A hot spot is any geography where a large number of high utilizers reside. High Utilizers are defined as any individual with 3 or more hospital admissions or 6 or more ER visits within 2 years. Hot spots range from blue (no hot spot) to red (intense hot spot)

Geocoding notes

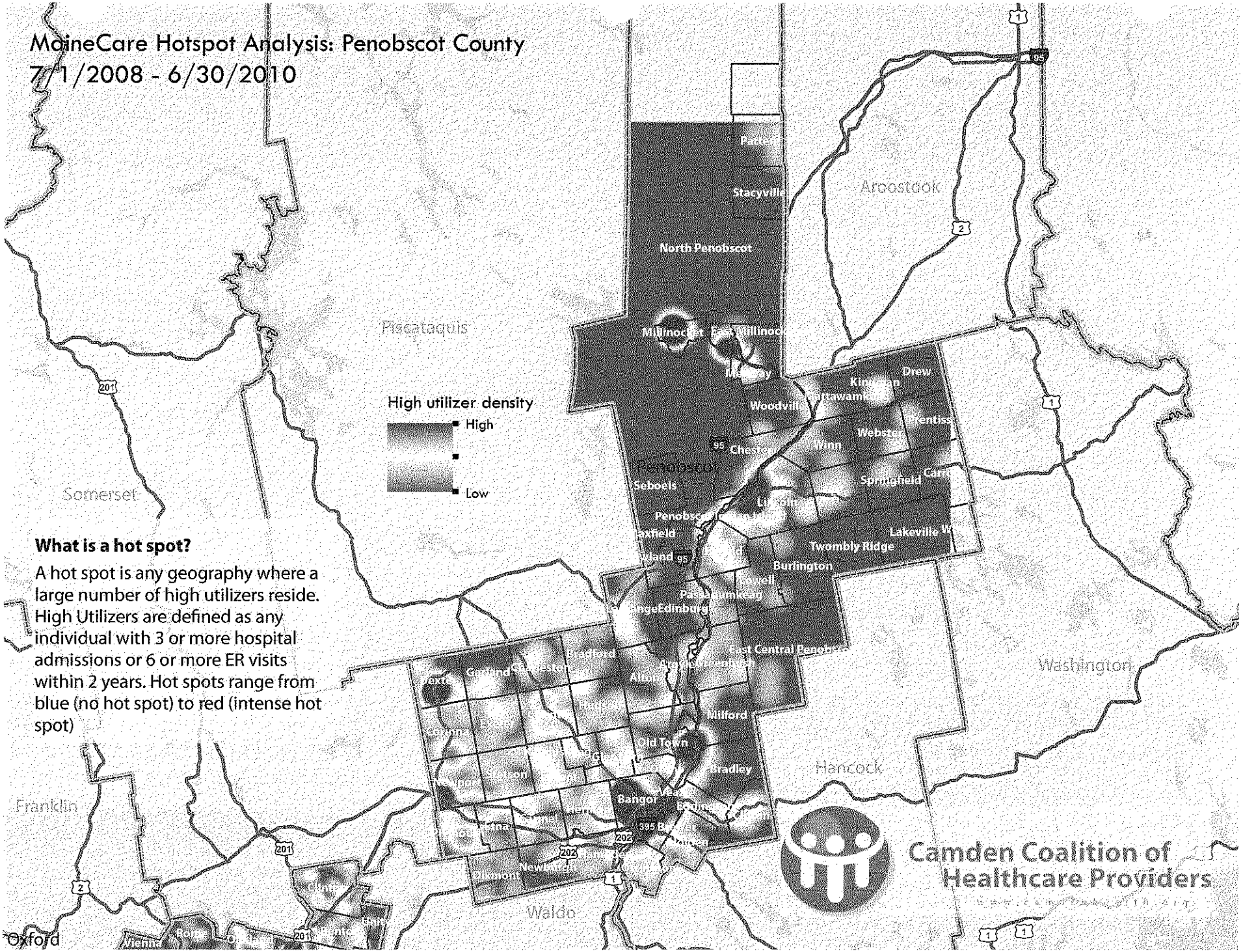
Individuals last addresses in the MaineCare database were used for all geospatial analyses. CCHP found 47,594 unique addresses in the three counties studied. Of these, 3,007 were PO Boxes, leaving 44,587 potential addresses. Through ArcGIS and other geospatial tools, CCHP was able to match 39,691 (89% success rate) of these addresses. Additional analysis was conducted to ensure that there were no geographic biases in unmatched addresses.

Camden Coalition of Healthcare Providers


MaineCare Hospital
Utilization Analysis
Portland Hot Spots*
7/1/2008 - 6/30/2010
High utilizer density
High
Low
In Portland's downtown area, on the peninsula south and west of Interstate 295, 6 buildings account for 515 members (6% of total Portland members), 79 high utilizers (8% of Portland's High Utilizers) resprenting $1,769,053 in total hospital spending. In one single building, 43 patients accounted for over $500k in ED and Inpatient costs over the two year period.
Camden Coalition of Healthcare Providers
Washington
Presumpscot
Veranda
Bates
Stevens
Walton
Read
Deering
Woodfords
Eastern
Walnut
Fox
Franklin
Marginal
Preble
Kloyes
Brighton
Deering
Park
100
State
77
High
York
Center
Valley
Saint James
Bramhall
Commercial
Broadway
22
1


MaineCare Hot Spot Analysis: Kennebec County
7/1/2008 - 6/30/2010
Franklin
Somerset
Waldo
Oxford
Androscoggin
Sagadahoc
Knox
Vienna
Belgrade
Mount Vernon
Fayette
Readfield
Oakland
Albion
Unity
Etna
Newburgh
Dixmont
Chelsea
Randolph
Pittston
Windsor
What is a hot spot?
A hot spot is any geography where a large number of high utilizers reside. High Utilizers are defined as any individual with 3 or more hospital admissions or 6 or more ER visits within 2 years. Hot spots range from blue (no hot spot) to red (intense hot spot)
High utilizer density
High
Low
Camden Coalition of Healthcare Providers

MaineCare Hotspot Analysis: Penobscot County
7/1/2008 - 6/30/2010



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THE NEW YORKER

MEDICAL REPORT

THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

by Atul Gawande

JANUARY 24, 2011

If Camden, New Jersey, becomes the first American community to lower its medical costs, it will have a murder to thank. At nine-fifty on a February night in 2001, a twenty-two-year-old black man was shot while driving his Ford Taurus station wagon through a neighborhood on the edge of the Rutgers University campus. The victim lay motionless in the street beside the open door on the driver's side, as if the car had ejected him. A neighborhood couple, a physical therapist and a volunteer firefighter, approached to see if they could help, but police waved them back.

In Camden, New Jersey, one per cent of patients account for a third of the city's medical costs. Photograph by Phillip Toledano.

"He's not going to make it," an officer reportedly told the physical therapist. "He's pretty much dead." She called a physician, Jeffrey Brenner, who lived a few doors up the street, and he ran to the scene with a stethoscope and a pocket ventilation mask. After some discussion, the police let him enter the crime scene and attend to the victim. Witnesses told the local newspaper that he was the first person to lay hands on the man.

"He was slightly overweight, turned on his side," Brenner recalls. There was glass everywhere. Although the victim had been shot several times and many minutes had passed, his body felt warm. Brenner checked his neck for a carotid pulse. The man was alive. Brenner began the chest compressions and rescue breathing that should have been started long before. But the young man, who turned out to be a Rutgers student, died soon afterward.

The incident became a local scandal. The student's injuries may not have been survivable, but the police couldn't have known that. After the ambulance came, Brenner confronted one of the officers to ask why they hadn't tried to rescue him.

"We didn't want to dislodge the bullet," he recalls the policeman saying. It was a ridiculous answer, a brushoff, and Brenner couldn't let it go.

He was thirty-one years old at the time, a skinny, thick-bearded, soft-spoken family physician who had grown up in a bedroom suburb of Philadelphia. As a medical student at Robert Wood Johnson Medical School, in Piscataway, he had planned to become a neuroscientist. But he volunteered once a week in a free primary-care clinic for poor immigrants, and he found the work there more challenging than anything he was doing in the laboratory. The guy studying neuronal stem cells soon became the guy studying Spanish and training to become one of the few family physicians in his class. Once he completed his residency, in 1998, he joined the staff of a family-medicine practice in Camden. It was in a cheaply constructed, boxlike, one-story building on a desolate street of bars, car-repair shops, and empty lots. But he was young and eager to recapture the sense of purpose he'd felt volunteering at the clinic during medical school.

Few people shared his sense of possibility. Camden was in civic free fall, on its way to becoming one of the poorest, most crime-ridden cities in the nation. The local school system had gone into receivership. Corruption and mismanagement soon prompted a state takeover of the entire city. Just getting the sewage system to work could be a problem. The neglect of this anonymous shooting victim on Brenner's street was another instance of a city that had given up, and Brenner was tired of wondering why it had to be that way.

Around that time, a police reform commission was created, and Brenner was asked to serve as one of its two citizen members. He agreed and, to his surprise, became completely absorbed. The experts they called in explained the basic principles of effective community policing. He learned about George Kelling and James Q. Wilson's "broken-windows" theory, which argued that minor, visible neighborhood disorder breeds major crime. He learned about the former New York City police commissioner William Bratton and the Compstat approach to policing that he had championed in the nineties, which centered on mapping crime and focussing resources on the hot spots. The reform panel pushed the Camden Police Department to create computerized crime maps, and to change police beats and shifts to focus on the worst areas and times.

When the police wouldn't make the crime maps, Brenner made his own. He persuaded Camden's three main hospitals to let him have access to their medical billing records. He transferred the reams of data files onto a desktop computer, spent weeks figuring out how to pull the chaos of information into a searchable database, and then started tabulating the emergency-room visits of victims of serious assault. He created maps showing where the crime

victims lived. He pushed for policies that would let the Camden police chief assign shifts based on the crime statistics—only to find himself in a showdown with the police unions.

"He has no clue," the president of the city police superiors' union said to the *Philadelphia Inquirer*. "I just think that his comments about what kind of schedule we should be on, how we should be deployed, are laughable."

The unions kept the provisions out of the contract. The reform commission disbanded; Brenner withdrew from the cause, beaten. But he continued to dig into the database on his computer, now mostly out of idle interest.

Besides looking at assault patterns, he began studying patterns in the way patients flowed into and out of Camden's hospitals. "I'd just sit there and play with the data for hours," he says, and the more he played the more he found. For instance, he ran the data on the locations where ambulances picked up patients with fall injuries, and discovered that a single building in central Camden sent more people to the hospital with serious falls—fifty-seven elderly in two years—than any other in the city, resulting in almost three million dollars in health-care bills. "It was just this amazing window into the health-care delivery system," he says.

So he took what he learned from police reform and tried a Compstat approach to the city's health-care performance—a Healthstat, so to speak. He made block-by-block maps of the city, color-coded by the hospital costs of its residents, and looked for the hot spots. The two most expensive city blocks were in north Camden, one that had a large nursing home called Abigail House and one that had a low-income housing tower called Northgate II. He found that between January of 2002 and June of 2008 some nine hundred people in the two buildings accounted for more than four thousand hospital visits and about two hundred million dollars in health-care bills. One patient had three hundred and twenty-four admissions in five years. The most expensive patient cost insurers $3.5 million.

Brenner wasn't all that interested in costs; he was more interested in helping people who received bad health care. But in his experience the people with the highest medical costs—the people cycling in and out of the hospital—were usually the people receiving the worst care. "Emergency-room visits and hospital admissions should be considered failures of the health-care system until proven otherwise," he told me—failures of prevention and of timely, effective care.

If he could find the people whose use of medical care was highest, he figured, he could do something to help them. If he helped them, he would also be lowering their health-care costs. And, if the stats approach to crime was right, targeting those with the highest health-care costs would help lower the entire city's health-care costs. His calculations revealed that just one per cent of the hundred thousand people who made use of Camden's medical facilities accounted

for thirty per cent of its costs. That's only a thousand people—about half the size of a typical family physician's panel of patients.

Things, of course, got complicated. It would have taken months to get the approvals needed to pull names out of the data and approach people, and he was impatient to get started. So, in the spring of 2007, he held a meeting with a few social workers and emergency-room doctors from hospitals around the city. He showed them the cost statistics and use patterns of the most expensive one per cent. "These are the people I want to help you with," he said. He asked for assistance reaching them. "Introduce me to your worst-of-the-worst patients," he said.

They did. Then he got permission to look up the patients' data to confirm where they were on his cost map. "For all the stupid, expensive, predictive-modelling software that the big venders sell," he says, "you just ask the doctors, 'Who are your most difficult patients?,' and they can identify them."

The first person they found for him was a man in his mid-forties whom I'll call Frank Hendricks. Hendricks had severe congestive heart failure, chronic asthma, uncontrolled diabetes, hypothyroidism, gout, and a history of smoking and alcohol abuse. He weighed five hundred and sixty pounds. In the previous three years, he had spent as much time in hospitals as out. When Brenner met him, he was in intensive care with a tracheotomy and a feeding tube, having developed septic shock from a gallbladder infection.

Brenner visited him daily. "I just basically sat in his room like I was a third-year med student, hanging out with him for an hour, hour and a half every day, trying to figure out what makes the guy tick," he recalled. He learned that Hendricks used to be an auto detailer and a cook. He had a longtime girlfriend and two children, now grown. A toxic combination of poor health, Johnnie Walker Red, and, it emerged, cocaine addiction had left him unreliably employed, uninsured, and living in a welfare motel. He had no consistent set of doctors, and almost no prospects for turning his situation around.

After several months, he had recovered enough to be discharged. But, out in the world, his life was simply another hospitalization waiting to happen. By then, however, Brenner had figured out a few things he could do to help. Some of it was simple doctor stuff. He made sure he followed Hendricks closely enough to recognize when serious problems were emerging. He double-checked that the plans and prescriptions the specialists had made for Hendricks's many problems actually fit together—and, when they didn't, he got on the phone to sort things out. He teamed up with a nurse practitioner who could make home visits to check blood-sugar levels and blood pressure, teach Hendricks about what he could do to stay healthy, and make sure he was getting his medications.

A lot of what Brenner had to do, though, went beyond the usual doctor stuff. Brenner got a social worker to help Hendricks apply for disability insurance, so that he could leave the chaos

of welfare motels, and have access to a consistent set of physicians. The team also pushed him to find sources of stability and value in his life. They got him to return to Alcoholics Anonymous, and, when Brenner found out that he was a devout Christian, he urged him to return to church. He told Hendricks that he needed to cook his own food once in a while, so he could get back in the habit of doing it. The main thing he was up against was Hendricks's hopelessness. He'd given up. "Can you imagine being in the hospital that long, what that does to you?" Brenner asked.

I spoke to Hendricks recently. He has gone without alcohol for a year, cocaine for two years, and smoking for three years. He lives with his girlfriend in a safer neighborhood, goes to church, and weathers family crises. He cooks his own meals now. His diabetes and congestive heart failure are under much better control. He's lost two hundred and twenty pounds, which means, among other things, that if he falls he can pick himself up, rather than having to call for an ambulance.

"The fun thing about this work is that you can be there when the light switch goes on for a patient," Brenner told me. "It doesn't happen at the pace we want. But you can see it happen."

With Hendricks, there was no miraculous turnaround. "Working with him didn't feel any different from working with any patient on smoking, bad diet, not exercising—working on any particular rut someone has gotten into," Brenner said. "People are people, and they get into situations they don't necessarily plan on. My philosophy about primary care is that the only person who has changed anyone's life is their mother. The reason is that she cares about them, and she says the same simple thing over and over and over." So he tries to care, and to say a few simple things over and over and over.

I asked Hendricks what he made of Brenner when they first met.

"He struck me as odd," Hendricks said. "His appearance was not what I expected of a young, clean-cut doctor." There was that beard. There was his manner, too. "His whole premise was 'I'm here for you. I'm not here to be a part of the medical system. I'm here to get you back on your feet.' "

An ordinary cold can still be a major setback for Hendricks. He told me that he'd been in the hospital four times this past summer. But the stays were a few days at most, and he's had no more cataclysmic, weeks-long I.C.U. stays.

Was this kind of success replicable? As word went out about Brenner's interest in patients like Hendricks, he received more referrals. Camden doctors were delighted to have someone help with their "worst of the worst." He took on half a dozen patients, then two dozen, then more. It became increasingly difficult to do this work alongside his regular medical practice. The clinic was already under financial strain, and received nothing for assisting these patients. If it were up to him, he'd recruit a whole staff of primary-care doctors and nurses and social

workers, based right in the neighborhoods where the costliest patients lived. With the tens of millions of dollars in hospital bills they could save, he'd pay the staff double to serve as Camden's élite medical force and to rescue the city's health-care system.

But that's not how the health-insurance system is built. So he applied for small grants from philanthropies like the Robert Wood Johnson Foundation and the Merck Foundation. The money allowed him to ramp up his data system and hire a few people, like the nurse practitioner and the social worker who had helped him with Hendricks. He had some desk space at Cooper Hospital, and he turned it over to what he named the Camden Coalition of Healthcare Providers. He spoke to people who had been doing similar work, studied "medical home" programs for the chronically ill in Seattle, San Francisco, and Pennsylvania, and adopted some of their lessons. By late 2010, his team had provided care for more than three hundred people on his "super-utilizer" map.

I spent a day with Kathy Jackson, the nurse practitioner, and Jessica Cordero, a medical assistant, to see what they did. The Camden Coalition doesn't have enough money for a clinic where they can see patients. They rely exclusively on home visits and phone calls.

Over the phone, they inquire about emerging health issues, check for insurance or housing problems, ask about unfilled prescriptions. All the patients get the team's urgent-call number, which is covered by someone who can help them through a health crisis. Usually, the issue can be resolved on the spot—it's a headache or a cough or the like—but sometimes it requires an unplanned home visit, to perform an examination, order some tests, provide a prescription. Only occasionally does it require an emergency room.

Patients wouldn't make the call in the first place if the person picking up weren't someone like Jackson or Brenner—someone they already knew and trusted. Even so, patients can disappear for days or weeks at a time. "High-utilizer work is about building relationships with people who are in crisis," Brenner said. "The ones you build a relationship with, you can change behavior. Half we can build a relationship with. Half we can't."

One patient I spent time with illustrated the challenges. If you were a doctor meeting him in your office, you would quickly figure out that his major problems were moderate developmental deficits and out-of-control hypertension and diabetes. His blood pressure and blood sugars were so high that, at the age of thirty-nine, he was already developing blindness and advanced kidney disease. Unless something changed, he was perhaps six months away from complete kidney failure.

You might decide to increase his insulin dose and change his blood-pressure medicine. But you wouldn't grasp what the real problem was until you walked up the cracked concrete steps of the two-story brownstone where he lives with his mother, waited for him to shove aside the old newspapers and unopened mail blocking the door, noticed Cordero's shake of the head

warning you not to take the rumpled seat he's offering because of the ant trail running across it, and took in the stack of dead computer monitors, the barking mutt chained to an inner doorway, and the rotten fruit on a newspaper-covered tabletop. According to a state evaluation, he was capable of handling his medications, and, besides, he lived with his mother, who could help. But one look made it clear that they were both incapable.

Jackson asked him whether he was taking his blood-pressure pills each day. Yes, he said. Could he show her the pill bottles? As it turned out, he hadn't taken any pills since she'd last visited, the week before. His finger-stick blood sugar was twice the normal level. He needed a better living situation. The state had turned him down for placement in supervised housing, pointing to his test scores. But after months of paperwork—during which he steadily worsened, passing in and out of hospitals—the team was finally able to get him into housing where his medications could be dispensed on a schedule. He had made an overnight visit the previous weekend to test the place out.

"I liked it," he said. He moved in the next week. And, with that, he got a chance to avert dialysis—and its tens of thousands of dollars in annual costs—at least for a while.

Not everyone lets the team members into his or her life. One of their patients is a young woman of no fixed address, with asthma and a crack-cocaine habit. The crack causes severe asthma attacks and puts her in the hospital over and over again. The team members have managed occasionally to track her down in emergency rooms or recognize her on street corners. All they can do is give her their number, and offer their help if she ever wanted it. She hasn't.

Work like this has proved all-consuming. In May, 2009, Brenner closed his regular medical practice to focus on the program full time. It remains unclear how the program will make ends meet. But he and his team appear to be having a major impact. The Camden Coalition has been able to measure its long-term effect on its first thirty-six super-utilizers. They averaged sixty-two hospital and E.R. visits per month before joining the program and thirty-seven visits after—a forty-per-cent reduction. Their hospital bills averaged $1.2 million per month before and just over half a million after—a fifty-six-per-cent reduction.

These results don't take into account Brenner's personnel costs, or the costs of the medications the patients are now taking as prescribed, or the fact that some of the patients might have improved on their own (or died, reducing their costs permanently). The net savings are undoubtedly lower, but they remain, almost certainly, revolutionary. Brenner and his team are out there on the boulevards of Camden demonstrating the possibilities of a strange new approach to health care: to look for the most expensive patients in the system and then direct resources and brainpower toward helping them.

Jeff Brenner has not been the only one to recognize the possibilities in focussing on the hot spots of medicine. One Friday afternoon, I drove to an industrial park on the outskirts of

Boston, where a rapidly growing data-analysis company called Verisk Health occupies a floor of a nondescript office complex. It supplies "medical intelligence" to organizations that pay for health benefits—self-insured businesses, many public employers, even the government of Abu Dhabi.

Privacy laws prevent U.S. employers from looking at the details of their employees' medical spending. So they hand their health-care payment data over to companies that analyze the patterns and tell them how to reduce their health-insurance spending. Mostly, these companies give financial advice on changing benefits—telling them, say, to increase employee co-payments for brand-name drugs or emergency-room visits. But even employers who cut benefits find that their costs continue to outpace their earnings. Verisk, whose clients pay health -care bills for fifteen million patients, is among the data companies that are trying a more sophisticated approach.

Besides the usual statisticians and economists, Verisk recruited doctors to dive into the data. I met one of them, Nathan Gunn, who was thirty-six years old, had completed his medical training at the University of California, San Francisco, and was practicing as an internist part time. The rest of his time he worked as Verisk's head of research. Mostly, he was in meetings or at his desk poring through "data runs" from clients. He insisted that it was every bit as absorbing as seeing sick patients—sometimes more so. Every data run tells a different human story, he said.

At his computer, he pulled up a data set for me, scrubbed of identifying information, from a client that manages health-care benefits for some two hundred and fifty employers—school districts, a large church association, a bus company, and the like. They had a hundred thousand "covered lives" in all. Payouts for those people rose eight per cent a year, at least three times as fast as the employers' earnings. This wasn't good, but the numbers seemed pretty dry and abstract so far. Then he narrowed the list to the top five per cent of spenders—just five thousand people accounted for almost sixty per cent of the spending—and he began parsing further.

"Take two ten-year-old boys with asthma," he said. "From a disease standpoint, they're exactly the same cost, right? Wrong. Imagine one of those kids never fills his inhalers and has been in urgent care with asthma attacks three times over the last year, probably because Mom and Dad aren't really on top of it." That's the sort of patient Gunn uses his company's medical-intelligence software program to zero in on—a patient who is sick and getting inadequate care. "That's really the sweet spot for preventive care," Gunn said.

He pulled up patients with known coronary-artery disease. There were nine hundred and twenty-one, he said, reading off the screen. He clicked a few more times and raised his eyebrows. One in seven of them had not had a full office visit with a physician in more than a year. "You can do something about that," he said.

"Let's do the E.R.-visit game," he went on. "This is a fun one." He sorted the patients by number of visits, much as Jeff Brenner had done for Camden. In this employed population, the No. 1 patient was a twenty-five-year-old woman. In the past ten months, she'd had twenty-nine E.R. visits, fifty-one doctor's office visits, and a hospital admission.

"I can actually drill into these claims," he said, squinting at the screen. "All these claims here are migraine, migraine, migraine, migraine, headache, headache, headache." For a twenty-five-year-old with her profile, he said, medical payments for the previous ten months would be expected to total twenty-eight hundred dollars. Her actual payments came to more than fifty-two thousand dollars—for "headaches."

Was she a drug seeker? He pulled up her prescription profile, looking for narcotic prescriptions. Instead, he found prescriptions for insulin (she was apparently diabetic) and imipramine, an anti-migraine treatment. Gunn was struck by how faithfully she filled her prescriptions. She hadn't missed a single renewal—"which is actually interesting," he said. That's not what you usually find at the extreme of the cost curve.

The story now became clear to him. She suffered from terrible migraines. She took her medicine, but it wasn't working. When the headaches got bad, she'd go to the emergency room or to urgent care. The doctors would do CT and MRI scans, satisfy themselves that she didn't have a brain tumor or an aneurysm, give her a narcotic injection to stop the headache temporarily, maybe renew her imipramine prescription, and send her home, only to have her return a couple of weeks later and see whoever the next doctor on duty was. She wasn't getting what she needed for adequate migraine care—a primary physician taking her in hand, trying different medications in a systematic way, and figuring out how to better keep her headaches at bay.

As he sorts through such stories, Gunn usually finds larger patterns, too. He told me about an analysis he had recently done for a big information-technology company on the East Coast. It provided health benefits to seven thousand employees and family members, and had forty million dollars in "spend." The firm had already raised the employees' insurance co-payments considerably, hoping to give employees a reason to think twice about unnecessary medical visits, tests, and procedures—make them have some "skin in the game," as they say. Indeed, almost every category of costly medical care went down: doctor visits, emergency-room and hospital visits, drug prescriptions. Yet employee health costs continued to rise—climbing almost ten per cent each year. The company was baffled.

Gunn's team took a look at the hot spots. The outliers, it turned out, were predominantly early retirees. Most had multiple chronic conditions—in particular, coronary-artery disease, asthma, and complex mental illness. One had badly worsening heart disease and diabetes, and medical bills over two years in excess of eighty thousand dollars. The man, dealing with higher

co-payments on a fixed income, had cut back to filling only half his medication prescriptions for his high cholesterol and diabetes. He made few doctor visits. He avoided the E.R.—until a heart attack necessitated emergency surgery and left him disabled with chronic heart failure.

The higher co-payments had backfired, Gunn said. While medical costs for most employees flattened out, those for early retirees jumped seventeen per cent. The sickest patients became much more expensive because they put off care and prevention until it was too late.

The critical flaw in our health-care system that people like Gunn and Brenner are finding is that it was never designed for the kind of patients who incur the highest costs. Medicine's primary mechanism of service is the doctor visit and the E.R. visit. (Americans make more than a billion such visits each year, according to the Centers for Disease Control.) For a thirty-year-old with a fever, a twenty-minute visit to the doctor's office may be just the thing. For a pedestrian hit by a minivan, there's nowhere better than an emergency room. But these institutions are vastly inadequate for people with complex problems: the forty-year-old with drug and alcohol addiction; the eighty-four-year-old with advanced Alzheimer's disease and a pneumonia; the sixty-year-old with heart failure, obesity, gout, a bad memory for his eleven medications, and half a dozen specialists recommending different tests and procedures. It's like arriving at a major construction project with nothing but a screwdriver and a crane.

Outsiders tend to be the first to recognize the inadequacies of our social institutions. But, precisely because they are outsiders, they are usually in a poor position to fix them. Gunn, though a doctor, mostly works for people who do not run health systems—employers and insurers. So he counsels them about ways to tinker with the existing system. He tells them how to change co-payments and deductibles so they at least aren't making their cost problems worse. He identifies doctors and hospitals that seem to be providing particularly ineffective care for high-needs patients, and encourages clients to shift contracts. And he often suggests that clients hire case-management companies—a fast-growing industry with telephone banks of nurses offering high-cost patients advice in the hope of making up for the deficiencies of the system.

The strategy works, sort of. Verisk reports that most of its clients can slow the rate at which their health costs rise, at least to some extent. But few have seen decreases, and it's not obvious that the improvements can be sustained. Brenner, by contrast, is reinventing medicine from the inside. But he does not run a health-care system, and had to give up his practice to sustain his work. He is an outsider on the inside. So you might wonder whether medical hot-spotting can really succeed on a scale that would help large populations. Yet there are signs that it can.

A recent Medicare demonstration program, given substantial additional resources under the new health-care-reform law, offers medical institutions an extra monthly payment to finance the coördination of care for their most chronically expensive beneficiaries. If total costs fall more than five per cent compared with those of a matched set of control patients, the program allows

institutions to keep part of the savings. If costs fail to decline, the institutions have to return the monthly payments.

Several hospitals took the deal when the program was offered, in 2006. One was the Massachusetts General Hospital, in Boston. It asked a general internist named Tim Ferris to design the effort. The hospital had twenty-six hundred chronically high-cost patients, who together accounted for sixty million dollars in annual Medicare spending. They were in nineteen primary-care practices, and Ferris and his team made sure that each had a nurse whose sole job was to improve the coördination of care for these patients. The doctors saw the patients as usual. In between, the nurses saw them for longer visits, made surveillance phone calls, and, in consultation with the doctors, tried to recognize and address problems before they resulted in a hospital visit.

Three years later, hospital stays and trips to the emergency room have dropped more than fifteen per cent. The hospital hit its five-per-cent cost-reduction target. And the team is just getting the hang of what it can do.

Recently, I visited an even more radically redesigned physician practice, in Atlantic City. Cross the bridge into town (Atlantic City is on an island, I learned), ignore the Trump Plaza and Caesars casinos looming ahead of you, drive a few blocks along the Monopoly-board streets (the game took its street names from here), turn onto Tennessee Avenue, and enter the doctors' office building that's across the street from the ninety-nine-cent store and the city's long-shuttered supermarket. On the second floor, just past the occupational-health clinic, you will find the Special Care Center. The reception area, with its rustic taupe upholstery and tasteful lighting, looks like any other doctors' office. But it houses an experiment started in 2007 by the health-benefit programs of the casino workers' union and of a hospital, AtlantiCare Medical Center, the city's two largest pools of employees.

Both are self-insured—they are large enough to pay for their workers' health care directly—and both have been hammered by the exploding costs. Yes, even hospitals are having a hard time paying their employees' medical bills. As for the union, its contracts are frequently for workers' total compensation—wages plus benefits. It gets a fixed pot. Year after year, the low-wage busboys, hotel cleaners, and kitchen staff voted against sacrificing their health benefits. As a result, they have gone without a wage increase for years. Out of desperation, the union's health fund and the hospital decided to try something new. They got a young Harvard internist named Rushika Fernandopulle to run a clinic exclusively for workers with exceptionally high medical expenses.

Fernandopulle, who was born in Sri Lanka and raised in Baltimore, doesn't seem like a radical when you meet him. He's short and round-faced, smiles a lot, and displays two cute rabbit teeth as he tells you how ridiculous the health-care system is and how he plans to change

it all. Jeff Brenner was on his advisory board, along with others who have pioneered the concept of intensive outpatient care for complex high-needs patients. The hospital provided the floor space. Fernandopulle created a point system to identify employees likely to have high recurrent costs, and they were offered the chance to join the new clinic.

The Special Care Center reinvented the idea of a primary-care clinic in almost every way. The union's and the hospital's health funds agreed to switch from paying the doctors for every individual office visit and treatment to paying a flat monthly fee for each patient. That cut the huge expense that most clinics incur from billing paperwork. The patients were given unlimited access to the clinic without charges—no co-payments, no insurance bills. This, Fernandopulle explained, would force doctors on staff to focus on service, in order to retain their patients and the fees they would bring.

The payment scheme also allowed him to design the clinic around the things that sick, expensive patients most need and value, rather than the ones that pay the best. He adopted an open-access scheduling system to guarantee same-day appointments for the acutely ill. He customized an electronic information system that tracks whether patients are meeting their goals. And he staffed the clinic with people who would help them do it. One nurse practitioner, for instance, was responsible for trying to get every smoker to quit.

I got a glimpse of how unusual the clinic is when I sat in on the staff meeting it holds each morning to review the medical issues of the patients on the appointment books. There was, for starters, the very existence of the meeting. I had never seen this kind of daily huddle at a doctor's office, with clinicians popping open their laptops and pulling up their patient lists together. Then there was the particular mixture of people who squeezed around the conference table. As in many primary-care offices, the staff had two physicians and two nurse practitioners. But a full-time social worker and the front-desk receptionist joined in for the patient review, too. And, outnumbering them all, there were eight full-time "health coaches."

Fernandopulle created the position. Each health coach works with patients—in person, by phone, by e-mail—to help them manage their health. Fernandopulle got the idea from the *promotoras*, community health workers, whom he had seen on a medical mission in the Dominican Republic. The coaches work with the doctors but see their patients far more frequently than the doctors do, at least once every two weeks. Their most important attribute, Fernandopulle explained, is a knack for connecting with sick people, and understanding their difficulties. Most of the coaches come from their patients' communities and speak their languages. Many have experience with chronic illness in their own families. (One was himself a patient in the clinic.) Few had clinical experience. I asked each of the coaches what he or she had done before working in the Special Care Center. One worked the register at a Dunkin' Donuts. Another was a Sears retail manager. A third was an administrative assistant at a casino.

"We recruit for attitude and train for skill," Fernandopulle said. "We don't recruit from health care. This kind of care requires a very different mind-set from usual care. For example, what is the answer for a patient who walks up to the front desk with a question? The answer is 'Yes.' 'Can I see a doctor?' 'Yes.' 'Can I get help making my ultrasound appointment?' 'Yes.' Health care trains people to say no to patients." He told me that he'd had to replace half of the clinic's initial hires—including a doctor—because they didn't grasp the focus on patient service.

In forty-five minutes, the staff did a rapid run-through of everyone's patients. They reviewed the requests that patients had made by e-mail or telephone, the plans for the ones who had appointments that day. Staff members made sure that all patients who made a sick visit the day before got a follow-up call within twenty-four hours, that every test ordered was reviewed, that every unexpected problem was addressed.

Most patients required no more than a ten-second mention. Mr. Green didn't turn up for his cardiac testing or return calls about it. "I know where his wife works. I'll track her down," the receptionist said. Ms. Blue is pregnant and on a high-blood-pressure medication that's unsafe in pregnancy. "I'll change her prescription right now," her doctor said, and keyed it in. A handful of patients required longer discussion. One forty-five-year-old heart-disease patient had just had blood tests that showed worsening kidney failure. The team decided to repeat the blood tests that morning, organize a kidney ultrasound in the afternoon if the tests confirmed the finding, and have him seen in the office at the end of the day.

A staff member read out the hospital census. Of the clinic's twelve hundred chronically ill patients, just one was in the hospital, and she was being discharged. The clinic's patients had gone four days without a single E.R. visit. On hearing this news, staffers cheered and broke into applause.

Afterward, I met a patient, Vibha Gandhi. She was fifty-seven years old and had joined the clinic after suffering a third heart attack. She and her husband, Bharat, are Indian immigrants. He cleans casino bathrooms for thirteen dollars an hour on the night shift. Vibha has long had poor health, with diabetes, obesity, and congestive heart failure, but things got much worse in the summer of 2009. A heart attack landed her in intensive care, and her coronary-artery disease proved so advanced as to be inoperable. She arrived in a wheelchair for her first clinic visit. She could not walk more than a few steps without losing her breath and getting a viselike chest pain. The next step for such patients is often a heart transplant.

A year and a half later, she is out of her wheelchair. She attends the clinic's Tuesday yoga classes. With the help of a walker, she can go a quarter mile without stopping. Although her condition is still fragile—she takes a purseful of medications, and a bout of the flu would send her back to an intensive-care unit—her daily life is far better than she once imagined.

"I didn't think I would live this long," Vibha said through Bharat, who translated her Gujarati for me. "I didn't want to live."

I asked her what had made her better. The couple credited exercise, dietary changes, medication adjustments, and strict monitoring of her diabetes.

But surely she had been encouraged to do these things after her first two heart attacks. What made the difference this time?

"Jayshree," Vibha said, naming the health coach from Dunkin' Donuts, who also speaks Gujarati.

"Jayshree pushes her, and she listens to her only and not to me," Bharat said.

"Why do you listen to Jayshree?" I asked Vibha.

"Because she talks like my mother," she said.

Fernandopulle carefully tracks the statistics of those twelve hundred patients. After twelve months in the program, he found, their emergency-room visits and hospital admissions were reduced by more than forty per cent. Surgical procedures were down by a quarter. The patients were also markedly healthier. Among five hundred and three patients with high blood pressure, only two were in poor control. Patients with high cholesterol had, on average, a fifty-point drop in their levels. A stunning sixty-three per cent of smokers with heart and lung disease quit smoking. In surveys, service and quality ratings were high.

But was the program saving money? The team, after all, was more expensive than typical primary care. And certain costs shot up. Because patients took their medications more consistently, drug costs were higher. The doctors ordered more mammograms and diagnostic tests, and caught and treated more cancers and other conditions. There's also the statistical phenomenon known as "regression to the mean": the super-high-cost patients may have been on their way to getting better (and less costly) on their own.

So the union's health fund enlisted an independent economist to evaluate the clinic's one-year results. According to the data, these workers made up a third of the local union's costliest ten per cent of members. To determine if the clinic was really making a difference, the economist compared their costs over twelve months with those of a similar group of Las Vegas casino workers. The results, he cautioned, are still preliminary. The sample was small. One patient requiring a heart transplant could wipe away any savings overnight. Nonetheless, compared with the Las Vegas workers, the Atlantic City workers in Fernandopulle's program experienced a twenty-five-per-cent drop in costs.

And this was just the start. The program, Fernandopulle told me, is still discovering new tricks. His team just recently figured out, for instance, that one reason some patients call 911 for problems the clinic would handle better is that they don't have the clinic's twenty-four-hour call number at hand when they need it. The health coaches told the patients to program it into their

cell-phone speed dial, but many didn't know how to do that. So the health coaches began doing it for them, and the number of 911 calls fell. High-cost habits are sticky; staff members are still learning the subtleties of unsticking them.

Their most difficult obstacle, however, has been the waywardness not of patients but of doctors—the doctors whom the patients see outside the clinic. Jeff Brenner's Camden patients are usually uninsured or on welfare; their doctors were happy to have someone else deal with them. The Atlantic City casino workers and hospital staff, on the other hand, had the best-paying insurance in town. Some doctors weren't about to let that business slip away.

Fernandopulle told me about a woman who had seen a cardiologist for chest pain two decades ago, when she was in her twenties. It was the result of a temporary, inflammatory condition, but he continued to have her see him for an examination and an electrocardiogram every three months, and a cardiac ultrasound every year. The results were always normal. After the clinic doctors advised her to stop, the cardiologist called her at home to say that her health was at risk if she didn't keep seeing him. She went back.

The clinic encountered similar troubles with some of the doctors who saw its hospitalized patients. One group of hospital-based internists was excellent, and coördinated its care plans with the clinic. But the others refused, resulting in longer stays and higher costs (and a fee for every visit, while the better group happened to be the only salaried one). When Fernandopulle arranged to direct the patients to the preferred doctors, the others retaliated, trolling the emergency department and persuading the patients to choose them instead.

" 'Rogues,' we call them," Fernandopulle said. He and his colleagues tried warning the patients about the rogue doctors and contacting the E.R. staff to make sure they knew which doctors were preferred. "One time, we literally pinned a note to a patient, like he was Paddington Bear," he said. They've ended up going to the hospital, and changing the doctors themselves when they have to. As the saying goes, one man's cost is another man's income.

The AtlantiCare hospital system is in a curious position in all this. Can it really make sense for a hospital to invest in a program, like the Special Care Center, that aims at reducing hospitalizations, even if its employees are included? I asked David Tilton, the president and C.E.O. of the system, why he was doing it. He had several answers. Some were of the it's-the-right-thing-to-do variety. But I was interested in the hard-nosed reasons. The Atlantic City economy, he said, could not sustain his health system's perpetually rising costs. His hospital either fought the pressure to control costs and went down with the local economy or learned how to benefit from cost control.

And there *are* ways to benefit. At a minimum, a successful hospital could attract patients from competitors, cushioning it against a future in which people need hospitals less. Two decades ago, for instance, Denmark had more than a hundred and fifty hospitals for its five

million people. The country then made changes to strengthen the quality and availability of outpatient primary-care services (including payments to encourage physicians to provide e-mail access, off-hours consultation, and nurse managers for complex care). Today, the number of hospitals has shrunk to seventy-one. Within five years, fewer than forty are expected to be required. A smart hospital might position itself to be one of the last ones standing.

Could anything that dramatic happen here? An important idea is getting its test run in America: the creation of intensive outpatient care to target hot spots, and thereby reduce overall health-care costs. But, if it works, hospitals will lose revenue and some will have to close. Medical companies and specialists profiting from the excess of scans and procedures will get squeezed. This will provoke retaliation, counter-campaigns, intense lobbying for Washington to obstruct reform.

The stats-and-stethoscope upstarts are nonetheless making their dash. Rushika Fernandopulle has set up a version of his Special Care program in Seattle, for Boeing workers, and is developing one in Las Vegas, for casino workers. Nathan Gunn and Verisk Health have landed new contracts during the past year with companies providing health benefits to more than four million employees and family members. Tim Ferris has obtained federal approval to spread his program for Medicare patients to two other hospitals in the Partners Healthcare System, in Boston (including my own). Jeff Brenner, meanwhile, is seeking to lower health-care costs for all of Camden, by getting its primary-care physicians to extend the hot-spot strategy citywide. We've been looking to Washington to find out how health-care reform will happen. But people like these are its real leaders.

During my visit to Camden, I attended a meeting that Brenner and several community groups had organized with residents of Northgate II, the building with the highest hospital billing in the city. He wanted to run an idea by them. The meeting took place in the building's ground-floor lounge. There was juice in Styrofoam cups and potato chips on little red plastic plates. A pastor with the Camden Bible Tabernacle started things off with a prayer. Brenner let one of the other coalition members do the talking.

How much money, he asked, did the residents think had been spent on emergency-room and hospital visits in the past five years for the people in this one building? They had no idea. He wrote out the numbers on an easel pad, but they were imponderable abstractions. The residents' eyes widened only when he said that the payments, even accounting for unpaid bills, added up to almost sixty thousand dollars per person. He asked how many of them believed that they had received sixty thousand dollars' worth of health care. That was when the stories came out: the doctors who wouldn't give anyone on Medicaid an office appointment; the ten-hour emergency-room waits for ten minutes with an intern.

Brenner was proposing to open a doctor's office right in their building, which would reduce their need for hospital visits. If it delivered better care and saved money, the doctor's office would receive part of the money that it saved Medicare and Medicaid, and would be able to add services—services that the residents could help choose. With enough savings, they could have same-day doctor visits, nurse practitioners at night, a social worker, a psychologist. When Brenner's scenario was described, residents murmured approval, but the mention of a social worker brought questions.

"Is she going to be all up in my business?" a woman asked. "I don't know if I like that. I'm not sure I want a social worker hanging around here."

This doctor's office, people were slowly realizing, would be involved in their lives—a medical professional would be after them about their smoking, drinking, diet, medications. That was O.K. if the person were Dr. Brenner. They knew him. They believed that he cared about them. Acceptance, however, would clearly depend upon execution; it wasn't guaranteed. There was similar ambivalence in the neighborhoods that Compstat strategists targeted for additional—and potentially intrusive—policing.

Yet the stakes in health-care hot-spotting are enormous, and go far beyond health care. A recent report on more than a decade of education-reform spending in Massachusetts detailed a story found in every state. Massachusetts sent nearly a billion dollars to school districts to finance smaller class sizes and better teachers' pay, yet every dollar ended up being diverted to covering rising health-care costs. For each dollar added to school budgets, the costs of maintaining teacher health benefits took a dollar and forty cents.

Every country in the world is battling the rising cost of health care. No community anywhere has demonstrably lowered its health-care costs (not just slowed their rate of increase) by improving medical services. They've lowered costs only by cutting or rationing them. To many people, the problem of health-care costs is best encapsulated in a basic third-grade lesson: you can't have it all. You want higher wages, lower taxes, less debt? Then cut health-care services.

People like Jeff Brenner are saying that we *can* have it all—teachers *and* health care. To be sure, uncertainties remain. Their small, localized successes have not yet been replicated in large populations. Up to a fourth of their patients face problems of a kind they have avoided tackling so far: catastrophic conditions. These are the patients who are in the top one per cent of costs because they were in a car crash that resulted in a hundred thousand dollars in surgery and intensive-care expenses, or had a cancer requiring seven thousand dollars a week for chemo and radiation. There's nothing much to be done for those patients, you'd think. Yet they are also victims of poor and disjointed service. Improving the value of the services—rewarding better results per dollar spent—could lead to dramatic innovations in catastrophic care, too.

The new health-reform law—Obamacare—is betting big on the Brenners of the world. It says that we can afford to subsidize insurance for millions, remove the ability of private and public insurers to cut high-cost patients from their rolls, *and* improve the quality of care. The law authorizes new forms of Medicare and Medicaid payment to encourage the development of "medical homes" and "accountable care organizations"—doctors' offices and medical systems that get financial benefits for being more accessible to patients, better organized, and accountable for reducing the over-all costs of care. Backers believe that, given this support, innovators like Brenner will transform health care everywhere.

Critics say that it's a pipe dream—more money down the health-care sinkhole. They could turn out to be right, Brenner told me; a well-organized opposition could scuttle efforts like his. "In the next few years, we're going to have absolutely irrefutable evidence that there are ways to reduce health-care costs, and they are 'high touch' and they are at the level of care," he said. "We are going to know that, hands down, this is possible." From that point onward, he said, "it's a political problem." The struggle will be to survive the obstruction of lobbies, and the partisan tendency to view success as victory for the other side.

Already, these forces of resistance have become Brenner's prime concern. He needs state legislative approval to bring his program to Medicaid patients at Northgate II and across Camden. He needs federal approval to qualify as an accountable care organization for the city's Medicare patients. In Camden, he has built support across a range of groups, from the state Chamber of Commerce to local hospitals to activist organizations. But for months—even as rising health costs and shrinking state aid have forced the city to contemplate further school cuts and the layoff of almost half of its police—he has been stalled. With divided branches at both the state and the federal level, "government just gets paralyzed," he says.

In the meantime, though, he's forging ahead. In December, he introduced an expanded computer database that lets Camden doctors view laboratory results, radiology reports, emergency-room visits, and discharge summaries for their patients from all the hospitals in town—and could show cost patterns, too. The absence of this sort of information is a daily impediment to the care of patients in Boston, where I practice. Right now, we're nowhere close to having such data. But this, I'm sure, will change. For in places like Camden, New Jersey, one of the poorest cities in America, there are people showing the way. ♦

Attachment C

National Cost Containment Efforts

Medicaid Cost Containment Actions Taken by States, FY2012

Table | Map | Map & Table

Rank By:
Region Name

	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Changes to Application and Renewal	LTC
United States	45+DC Yes	38 Yes	17+DC Yes	3 Yes	14 Yes	1 Yes	11 Yes
Alabama	Yes	Yes	No	No	No	No	No
Alaska	No	Yes	No	No	No	No	No
Arizona	Yes	Yes	Yes	Yes	Yes	No	Yes
Arkansas	Yes	Yes	No	No	No	No	No
California	Yes	Yes	Yes	No	Yes	No	No
Colorado	Yes	Yes	Yes	No	No	No	No
Connecticut	Yes	Yes	Yes	Yes	No	No	No
Delaware	Yes	Yes	No	No	No	No	No
District of Columbia	Yes	No	Yes	No	No	No	No
Florida	Yes	No	No	No	Yes	No	No
Georgia	Yes	Yes	No	No	Yes	No	No
Hawaii	Yes	Yes	Yes	Yes	No	No	No
Idaho	Yes	Yes	Yes	No	Yes	No	No
Illinois	Yes	Yes	No	No	Yes	Yes	No
Indiana	Yes	Yes	Yes	No	No	No	No
Iowa	No	Yes	Yes	No	Yes	No	No
Kansas	Yes	Yes	No	No	No	No	No
Kentucky	Yes	No	No	No	No	No	No
Louisiana	Yes	No	No	No	No	No	No
Maine	Yes	Yes	No	No	Yes	No	No
Maryland	Yes	Yes	No	No	No	No	No
Massachusetts	Yes	No	No	No	Yes	No	Yes
Michigan	Yes	Yes	Yes	No	No	No	No
Minnesota	Yes	Yes	No	No	Yes	No	Yes
Mississippi	Yes	Yes	No	No	No	No	No
Missouri	Yes	No	No	No	No	No	No
Montana	Yes	Yes	No	No	No	No	Yes
Nebraska	Yes	No	No	No	Yes	No	Yes
Nevada	Yes	Yes	No	No	No	No	No
New Hampshire	Yes	Yes	Yes	No	No	No	No
New Jersey	Yes	No	No	No	No	No	Yes
New Mexico	Yes	No	Yes	No	No	No	No
New York	Yes	Yes	Yes	No	No	No	No
North Carolina	Yes	Yes	Yes	No	Yes	No	No
North Dakota	No	No	No	No	No	No	No
Ohio	Yes	No	No	No	No	No	Yes
Oklahoma	Yes	No	No	No	No	No	No
Oregon	Yes	Yes	Yes	No	No	No	No
Pennsylvania	Yes	Yes	Yes	No	Yes	No	No
Rhode Island	Yes	No	No	No	No	No	Yes
South Carolina	Yes	Yes	No	No	Yes	No	Yes
South Dakota	Yes	Yes	No	No	No	No	No
Tennessee	Yes	Yes	No	No	No	No	No
Texas	Yes	Yes	Yes	No	No	No	No
Utah	Yes	Yes	No	No	No	No	No
Vermont	Yes	Yes	No	No	No	No	No
Virginia	Yes	Yes	No	No	No	No	Yes
Washington	Yes	Yes	Yes	No	No	No	No
West Virginia	No	Yes	No	No	No	No	No
Wisconsin	No	Yes	No	No	No	No	Yes
Wyoming	Yes	Yes	No	No	No	No	No

(show/hide notes)

Sources: *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*, Appendix A-2. Kaiser Commission on Medicaid and the Uninsured, October 2011. Available at: http://www.kff.org/medicaid/8248.cfm.

Definitions: **Provider Payments:** Provider payment rate change, which may involve a payment rate freeze or cut. Providers include physicians, inpatient hospitals, nursing homes and managed care organizations.
Pharmacy Controls: Pharmacy utilization or cost control initiatives including subjecting more drugs to prior authorization, implementing or expanding preferred drug lists, and seeking new or enhanced supplemental rebates.
Benefit Reductions: Benefits restrictions, reductions or eliminations.
Eligibility Cuts: Eligibility reductions or restrictions. This may involve changes to eligibility standards, application and renewal process, or premiums. Other actions restricting eligibility include increasing the asset transfer look-back period from three to five years, limiting countable prior medical bills to those incurred within three months of application, increasing the waiting period from six to nine months, and freezing enrollment.
Copays: New or higher copayments for services. In imposing copayments, states must comply with Federal Medicaid law, which specifies that copayments must be "nominal", generally defined as $3.00 or less per service. The law also provides exemptions so copayments cannot apply to certain services or certain eligibility groups such as children or pregnant women. Federal law requires that a provider must render a service regardless of whether the copayment is collected.
LTC: Cost containment initiatives for long term care and home and community based services programs.

Federal Fiscal Year: Unless otherwise noted, years proceeded by "FY" on statehealthfacts.org refer to the Federal Fiscal Year, which runs from October 1 through September 30. For example, FY 2009 refers to the period from October 1, 2008 through September 30, 2009.

Attachment D

National Medicaid Changes

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012

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Executive Summary

The Great Recession continued to affect states at the end of state fiscal year (FY) 2011 and heading into FY 2012, although positive signs were beginning to emerge. State revenues were still below pre-recession levels, but were moving in a positive direction and Medicaid enrollment and spending growth were starting to taper. While Medicaid directors noted some positive signs of economic recovery, improvements remained fragile and slow in many states. State budgets for FY 2012 had to account for the expiration of the temporary federal fiscal relief provided through the American Recovery and Reinvestment Act of 2009 (ARRA). Thus, for FY 2012, nearly every state continued to focus on actions to control costs in Medicaid including restrictions on provider rates and benefits and new controls on prescription drug spending. At the same time, states also were moving forward with payment and delivery system reforms by expanding managed care programs and by continuing to re-orient long-term care programs to community-based care models. Eligibility for Medicaid remained stable due to the maintenance of eligibility (MOE) protections that were part of ARRA and health reform, and a number of states reported targeted eligibility expansions or simplified enrollment procedures.

Despite historically difficult budget conditions, states were also planning for the implementation of the Patient Protection and Affordable Care Act (ACA). Under the ACA, states will play key roles in implementing both Medicaid and private insurance coverage changes set to take effect in 2014. Medicaid is the foundation for the ACA coverage expansions for the low-income population, which will significantly reduce the number of uninsured. While the program is set to expand under the ACA in 2014, states worry about the implications of looming federal deficit reduction efforts and the policy and financing implications for Medicaid and states.

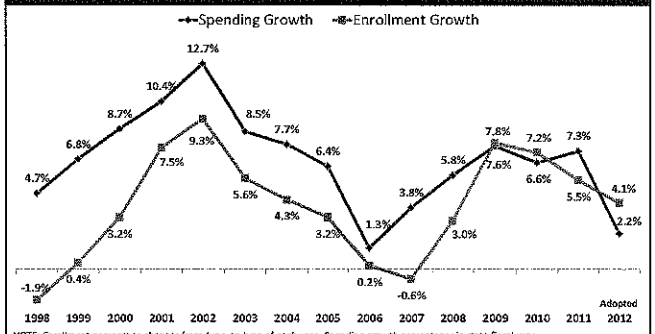
These findings are drawn from the 11th consecutive year of the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. The report provides detailed appendices with state-by-state information as well as a more in depth look through case studies of the Medicaid budget and policy conditions in Minnesota, New York and Tennessee. Key findings from the survey are highlighted below.

As a result of the recession, states experienced robust Medicaid spending and enrollment growth in FY 2011, but states are projecting lower growth for FY 2012 (Figure ES-1). Medicaid spending increased on average by 7.3 percent across all states in FY 2011 – very close to original projections of 7.4 percent growth. For FY 2012, legislatures authorized spending growth that averaged 2.2 percent, one of the lowest rates on record. Eleven states projected actual spending decreases. In some cases, these projections may understate actual spending increases for FY 2012 given that Medicaid officials in over half of the states reported a 50-50 chance of a Medicaid budget shortfall and almost one-quarter indicated a Medicaid budget shortfall was almost certain for FY 2012.

Enrollment growth, which drives spending growth, averaged 5.5 percent in FY 2011, somewhat lower than the 6.1 percent growth rate projected at the start of FY 2011. For FY 2012, states projected that the rate of enrollment growth, on average, would slow to 4.1 percent.

ES-1

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2012

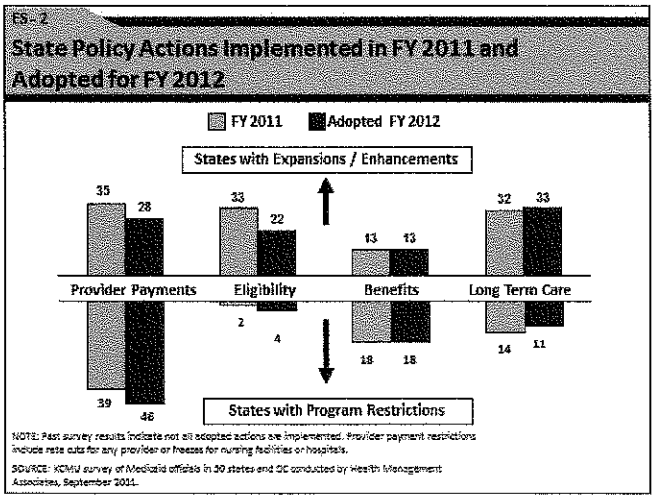


NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: *Medicaid Enrollment June 2010 Data Snapshot*, KCMU, February 2011. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates, FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

Increased federal assistance through the ARRA enhanced Federal Matching Percentage (FMAP) reduced the state share of Medicaid costs in FY 2009 and FY 2010, but the expiration of these funds means large increases in state funding for Medicaid in FY 2012. From October 2008 through June 2011 states received federal fiscal relief from ARRA in the form of an enhanced federal match rate for Medicaid. These funds helped states support state budgets and their Medicaid programs. The ARRA enhanced FMAP reduced the state costs for Medicaid by increasing the federal share, resulting in an average decline in state spending for Medicaid of 4.9 percent in FY 2010, following a drop of 10.9 percent in FY 2009. These were the only two declines in state annual spending for Medicaid in the program's history. As the ARRA enhanced FMAP began to phase down over the final two quarters of the 2011 state fiscal year, state spending increased on average by 10.8 percent for FY 2011. ARRA funds expired entirely as most states began FY 2012 when federal matching rates returned to statutory calculated levels. As a result, state spending had to be increased to replace the enhanced federal funds, contributing to large increases in state spending for Medicaid of 28.7 percent in FY 2012.

Nearly every state implemented at least one new Medicaid policy to control spending in FYs 2011 and 2012, but many states also implemented some expansions in eligibility and home and community based long-term care (ES-2). In FY 2011, 47 states implemented at least one new policy to control Medicaid costs and 50 states planned to do so in FY 2012. Most states reported program reductions in multiple areas. Highlights of Medicaid policy changes for FY 2011 and FY 2012 include the following:



- ***The ARRA and ACA MOE provisions prevented states from restricting their Medicaid eligibility standards, methodologies or procedures, and despite tight budgets, many states reported eligibility expansions or enrollment simplifications.*** Thirty-three states in FY 2011 and 22 states in FY 2012 reported moving forward with positive eligibility changes. Minnesota joined Connecticut and the District of Columbia in implementing Medicaid coverage for childless adults under a new option in the ACA and several other states expanded coverage to this population through 1115 waivers. More states opted to cover legal immigrant children and pregnant women living in the United States for less than five years (the "ICHIA" option)[1] and several states also moved to expand coverage for family planning services (oftentimes using new authority in the ACA to do so through a state plan

[1] Taking its name from the earlier proposed Immigrant Children's Health Improvement Act (ICHIA).

amendment instead of a wavier). In addition, many states reported efforts to streamline their enrollment processes in FY 2011 and FY 2012. More states reported new or enhanced abilities to apply or renew Medicaid coverage through on-line applications, implementation or expansion of Express Lane Eligibility, and changes to administrative and passive renewals. A number of these changes help states qualify for performance bonus payments enacted as part of the Children's Health Insurance Program Reauthorization Act. Two states made notable eligibility restrictions that are allowed under MOE exceptions for expiring waivers (Arizona) and for coverage of adults with incomes above 133 percent of poverty in states with budget deficits (Hawaii, for January, 2012 pending approval).

- ***As in previous years, provider rate restrictions were the most commonly reported cost containment strategy.*** During economic downturns, states tend to freeze or reduce provider rates, but often restore or enhance them when conditions improve. A total of 39 states restricted provider rates in FY 2011 and 46 states reported plans to do so in FY 2012. A number of states, however, increased or imposed new provider taxes that mitigated provider cuts in some cases. States must balance the goal of controlling costs through provider rate cuts with the need to comply with the federal requirement to ensure that provider rates are sufficient to maintain adequate provider participation and access to services for enrollees. On October 3, 2011, the Supreme Court heard oral arguments in a group of cases from California that challenged reimbursement rate reductions. The court will be ruling on the narrower question of whether Medicaid providers and beneficiaries should be allowed to bring this lawsuit seeking to enforce federal Medicaid law. In May 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would, for the first time, provide federal regulatory guidance regarding what states must do to demonstrate compliance with Medicaid's statutory access requirements.

- ***States continue to restrict benefits and implement cost containment strategies focused on prescription drugs.*** Eighteen states in both FYs 2011 and 2012 reported eliminating, reducing or restricting benefits. Elimination of, or limits on, dental, therapies, medical supplies and DME and personal care services were most frequently reported. Over the past decade, almost all state Medicaid programs have made substantial changes in their pharmacy programs by employing a variety of sophisticated pharmacy management tools including preferred drug lists (PDLs), supplemental rebates, prior authorization and other utilization management efforts. States continue to implement and refine these strategies. Many states are also looking at new reimbursement methodologies for prescription drugs and implementing initiatives that focus on specialty drugs which represent a large and growing share of prescription drug spending.

- ***There is a notable increase in the number of states raising or imposing new copayments on beneficiaries.*** Copayments are currently required by most state Medicaid programs for various services - particularly prescription drugs for adults. States are generally permitted to impose nominal copayments on services for certain beneficiaries, although the Deficit Reduction Act (DRA) allowed more flexibility under certain circumstances. Most children on Medicaid have been exempt from paying copayments under federal law. Five states in FY 2011 and 14 states in FY 2012 increased copayment amounts or imposed new copayments. In contrast, only one state did so in FY 2010. Most copayment changes were for pharmacy and emergency room visits, although a few states, including Arizona, California and Florida are requesting broader authority through waivers to impose copayments beyond nominal levels and to exempt populations. A recent Federal Court of Appeals decision questions the authority of the Secretary to use waiver demonstration authority to allow states to impose copayments, which may affect how CMS will rule on these pending waiver requests.

- ***States continue to re-orient the delivery of long-term care to shift care away from institutions and into community settings.*** Thirty-two states in FY 2011 and 33 states in FY 2012 took actions that expanded LTC services (primarily expanding home and community-based service (HCBS) programs). Conversely, a total of 14 states in FY 2011 and 11 states in FY 2012 took action to restrict LTC services. The ACA included a number of new long-term care options designed to increase community based long-term services and supports. Most states are still undecided as to whether to adopt these options, although four states were moving forward with the State Balancing Incentive Payment Program (Connecticut, Missouri, New Jersey and Rhode Island) and three states planned to implement the Community First Choice Option (Alaska, Rhode Island and Washington). By 2012, 43 states reported that they had implemented or plan to implement the Money Follows the Person Rebalancing Demonstration (with funding extended by the ACA).

States continue to adopt policies to expand managed care and enhance quality. Seventeen states in FY 2011 and nearly half (24 states) in FY 2012 reported that they were expanding their managed care programs primarily by expanding the areas and populations covered by managed care programs. Some states including Kentucky, Louisiana, New Jersey, New York and Texas are implementing either new or significant expansions of comprehensive managed care programs. States are also expanding the use of disease and care management programs and patient centered medical homes to help coordinate care and focus on high-cost and high-need populations. States are using managed care as a vehicle to implement quality and performance strategies such as tying payment or default enrollment to performance and adding quality measures for reporting.

New initiatives related to systems of integrated, coordinated care to serve dual Medicare – Medicaid eligibles were a top priority in FY 2011 and FY 2012. The ACA created two new offices (the Medicare-Medicaid Coordination Office and the Center on Medicare and Medicaid Innovation) that are working with states to facilitate new approaches to improve the care for this population. In April 2011, CMS awarded $1 million in planning contracts to each of 15 states for the development of integrated systems to serve dual eligibles. In July 2011, CMS released guidance that it would assist additional states in developing payment and delivery systems that would facilitate the coordination and integration of care for duals. Many states, including several of the 15 states who received contracts in April 2011, indicated that they had planned to submit proposals. Since the time of the survey, CMS has announced that 37 states have submitted letters of intent related to the opportunities announced by CMS in July 2011.[2] Tied to the grants and guidance and other state efforts, several states reported efforts to implement or expand managed long-term care programs for duals and other long-term care populations including New York, Tennessee, Texas, and California.

A number of states are pursuing Section 1115 Medicaid Demonstration Waivers to make program changes not otherwise allowable under federal Medicaid law. The majority of states with waiver plans reported significant delivery system and/or provider payment reforms for broad or targeted populations including duals or individuals with disabilities and special health care needs. Some states have approval from CMS for certain program changes or have applications pending; other states are still developing proposals and have not yet submitted formal applications to CMS.

Over the next few years, states will be required to implement significant health information technology (HIT) changes. Four major HIT initiatives are common across most states, with timelines for implementation that are driven by national deadlines: Medicaid Electronic Health Record (EHR) certification and incentive programs; major upgrades to claims payment systems; updates to the coding system for medical claims, and implementation of health reform in 2014, which requires major Medicaid IT development, particularly for Medicaid eligibility systems, and integration with new systems developed for state Health Insurance

[2] For more information, including a list of states that submitted letters of intent, see: http://www.cms.gov/medicare-medicaid-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf.

Exchanges. In addition, states are also using data systems to monitor for fraud and abuse to assure the highest level of fiscal and program integrity.

As states continue to grapple with historically difficult budget conditions, they must also plan for the implementation of the ACA which envisions new roles for Medicaid and for states. Under health reform, Medicaid will be expanded to cover nearly all individuals with incomes below 133 percent of poverty resulting in a large adult expansion in most states. Medicaid officials are playing a lead role in preparing for health reform implementation, in many cases alongside insurance commissioners. While reform presents the opportunity to dramatically reduce the number of uninsured, states identified a number of concerns related to ACA implementation including the fiscal impact of health care reform, tight implementation timelines, lack of clear federal guidance, limited staff and administrative resources, the need to streamline eligibility and coordinate with new exchanges, systems and IT issues, provider access issues, and political challenges in states with significant ACA opposition. State officials also discussed some of the issues and questions associated with transitioning to the new Modified Adjusted Gross Income (MAGI) eligibility methodology. (Concerns about MAGI were largely raised prior to the release of a proposed rule on these issues by CMS on August 4, 2011). To help develop new eligibility systems, three-quarters of the states indicated that they would take advantage of the new 90 percent federal match rate for eligibility systems made available under a final CMS regulation adopted in April 2011.

Looking to the future, Medicaid is poised to play a greater role in health care coverage, to lead the way in innovative payment and delivery models, and to remain front and center in state and federal budget discussions. Despite the intense focus on cost containment efforts due to unrelenting fiscal pressure, Medicaid directors pointed to a range of program improvements and strategies now underway particularly related to care delivery and payment systems. These initiatives are designed to improve the program in the near term and to better position the program for the ACA required eligibility expansions to cover more low-income Americans. However, as states take on the immediate challenges of running their programs and look to the implementation of health reform, they raised concerns that federal discussions related to debt and deficit reduction might achieve federal savings by shifting more Medicaid costs to states, thereby compromising their ability to move forward. In many ways, Medicaid programs have proven to be a resilient part of the nation's health care infrastructure, innovating and adapting to opportunities afforded by an evolving health care system and implementing new provisions of federal law while holding down cost increases. The current challenges may appear daunting, but Medicaid directors communicated that they and their programs are poised for a greater role in health care delivery and are committed to assuring access to high quality care delivered in the most effective manner possible.

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This publication (#8248-ES) is available on the Kaiser Family Foundation's website at www.kff.org.

Attachment E

Historical Medicaid Spending

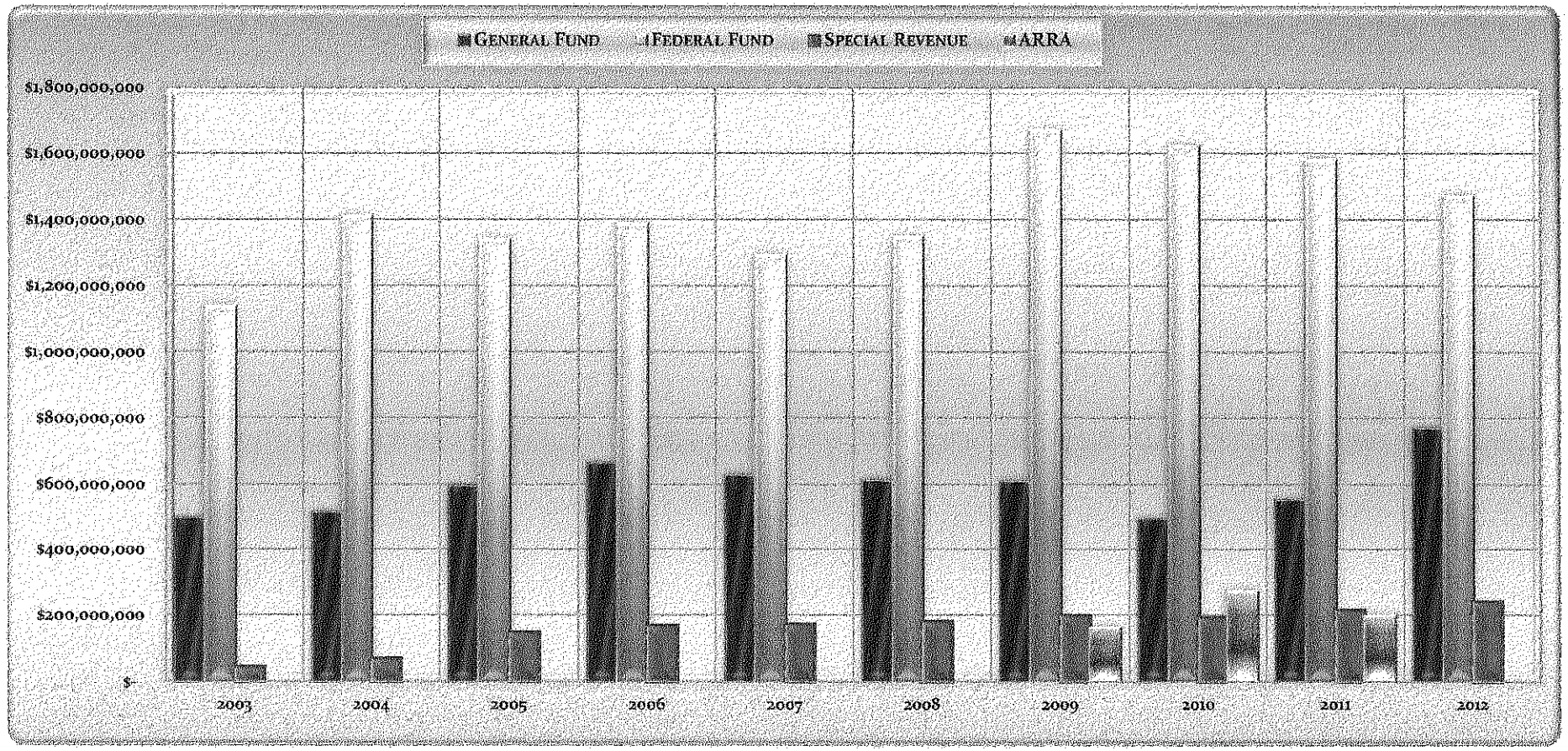
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Breakdown of Actual MaineCare Expenditures by Fund 1996 - 2012

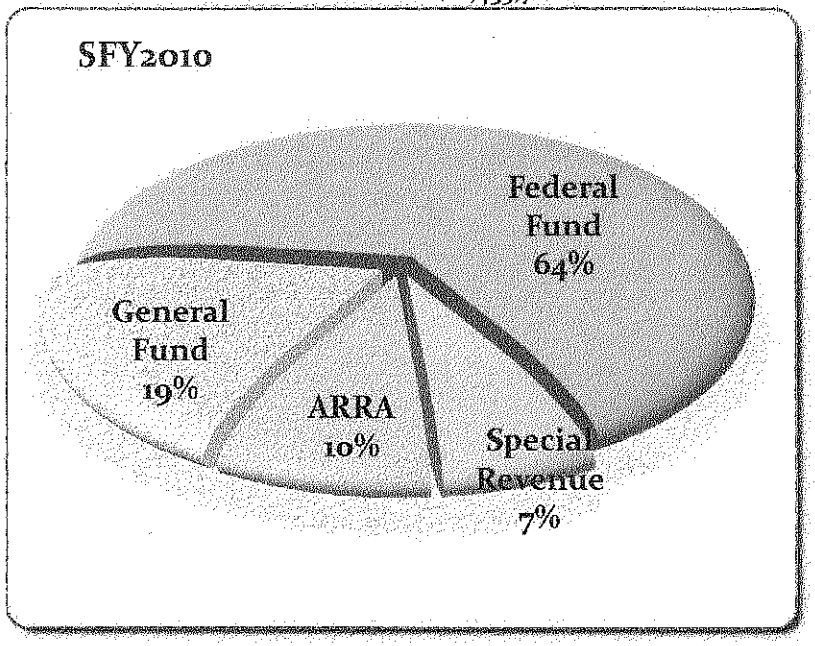
State Fiscal Year	General Fund	Annual % Change	Fund for a Healthy Maine (FHM)	Other Special Revenue (OSR) Funds	**State Funds Total**	***Annual % Change***	Federal Expenditure Funds	Federal AARA Funds	Federal Block Grant Funds	**Total Federal Funds**	***Annual % Change***	**Total All Funds**	***Annual % Change***
1996	220,034,610		0	123,154,525	**343,189,135**		605,979,614	0	0	**605,979,614**		**949,168,749**	
1997	232,572,193	5.70%	0	139,455,851	**372,028,044**	***8.40%***	658,001,950	0	0	**658,001,950**	***8.58%***	**1,030,029,994**	***8.52%***
1998	256,075,045	10.11%	0	127,593,970	**383,669,015**	***3.13%***	708,405,752	0	0	**708,405,752**	***7.66%***	**1,092,074,767**	***6.02%***
1999	377,735,735	47.51%	0	0	**377,735,735**	***-1.55%***	743,618,685	0	231,647	**743,850,332**	***5.00%***	**1,121,586,067**	***2.70%***
2000	416,464,306	10.25%	0	0	**416,464,306**	***10.25%***	789,153,813	0	8,373,161	**797,526,974**	***7.22%***	**1,213,991,280**	***8.24%***
2001	442,827,243	6.33%	3,500,000	0	**446,327,243**	***7.17%***	856,780,077	0	10,436,327	**867,216,404**	***8.74%***	**1,313,543,647**	***8.20%***
2002	476,477,914	7.60%	15,800,128	1,909,961	**494,188,003**	***10.72%***	934,884,181	0	13,392,657	**948,276,838**	***9.35%***	**1,442,464,841**	***9.81%***
2003	500,674,001	5.08%	18,488,955	23,586,924	**542,749,880**	***9.83%***	1,121,271,762	0	17,897,814	**1,139,169,576**	***20.13%***	**1,681,919,456**	***16.60%***
2004	518,712,898	3.60%	18,510,215	47,416,800	**584,639,913**	***7.72%***	1,393,282,526	0	19,628,828	**1,412,911,354**	***24.03%***	**1,997,551,267**	***18.77%***
2005	595,212,790	14.75%	18,181,320	126,177,717	**739,571,827**	***26.50%***	1,324,225,493	0	18,117,002	**1,342,342,495**	***-4.99%***	**2,081,914,322**	***4.22%***
2006	658,402,583	10.62%	8,101,979	157,081,315	**823,585,877**	***11.36%***	1,371,171,554	0	18,438,747	**1,389,610,301**	***3.52%***	**2,213,196,178**	***6.31%***
2007	619,221,147	-5.95%	11,675,647	157,054,249	**787,951,043**	***-4.33%***	1,268,901,593	0	24,663,347	**1,293,564,940**	***-6.91%***	**2,081,515,983**	***-5.95%***
2008	622,399,231	0.51%	10,592,135	167,153,841	**800,145,207**	***1.55%***	1,326,423,798	0	23,961,829	**1,350,385,627**	***4.39%***	**2,150,530,834**	***3.32%***
2009	573,951,351	-7.78%	8,566,936	174,432,230	**756,950,517**	***-5.40%***	1,576,881,805	162,473,129	27,780,417	**1,767,135,351**	***30.86%***	**2,524,085,868**	***17.37%***
2010	452,298,284	-21.20%	6,396,059	168,776,440	**627,470,783**	***-17.11%***	1,536,627,525	240,869,091	28,813,827	**1,806,310,443**	***2.22%***	**2,433,781,226**	***-3.58%***
2011	497,621,683	10.02%	6,215,038	188,993,452	**692,830,173**	***10.42%***	1,501,419,470	198,997,107	26,770,428	**1,727,187,005**	***-4.38%***	**2,420,017,178**	***-0.57%***
2012	736,927,585	48.09%	9,141,702	$220,732,855	**966,802,142**	***39.54%***	1,450,291,829	(4,420,541)	26,229,321	**1,472,100,609**	***-14.77%***	**2,438,902,751**	***0.78%***

Department of Health & Human Services
Total MaineCare Expenditures
SFY 2003 thru SFY 2012

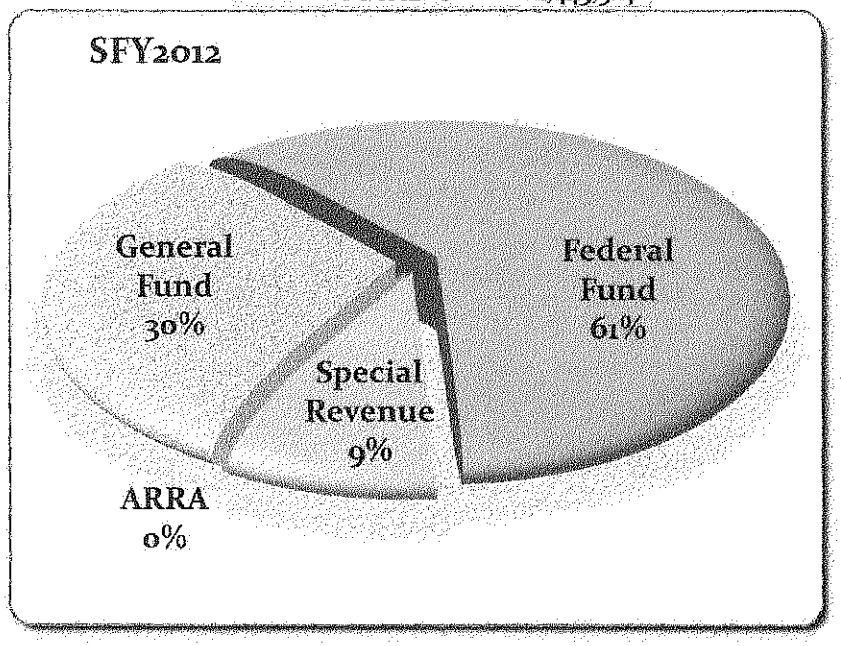
SFY	General Fund	Federal Fund	Special Revenue	ARRA
2003	$ 496,614,427	$ 1,139,169,576	$ 47,531,948	
2004	$ 514,128,562	$ 1,412,911,354	$ 70,017,321	
2005	$ 595,212,790	$ 1,342,342,496	$ 148,827,163	
2006	$ 665,307,427	$ 1,389,610,301	$ 169,112,078	
2007	$ 628,959,785	$ 1,293,564,940	$ 173,041,168	
2008	$ 613,008,933	$ 1,350,385,627	$ 182,876,293	
2009	$ 609,006,871	$ 1,670,623,303	$ 200,903,020	$ 79,473,330
2010	$ 492,315,864	$ 1,624,486,594	$ 194,340,200	$ 276,110,258
2011	$ 552,273,801	$ 1,581,930,911	$ 217,337,020	$ 169,190,654
2012	$ 769,774,525	$ 1,472,100,614	$ 242,840,170	



MaineCare Expenditures SFY 2010	
	Total
General Fund	$ 452,298
Federal Fund	$ 1,565,441
Special Revenue	$ 175,172
ARRA	$ 240,869
TOTAL	$ 2,433,780



MaineCare Expenditures SFY 2012	
	Total
General Fund	$ 736,928
Federal Fund	$ 1,476,521
Special Revenue	$ 229,875
ARRA	$ -
TOTAL	$ 2,443,324



Attachment F

MaineCare Caseload, SFY 2001 - 2012

MaineCare Caseload, SFY 2001 - 2012

Maine Department of Health and Human Services - DHHS Service Center

SFY	Month	Traditional Medicaid[1]	Medicaid Expansion[2]	"Cub Care"[2]	101% FPL To 150% FPL[3]	151% FPL To 200% FPL[3]	Childless Adult Waiver[4]	MaineCare AND DEL/ Me Rx[5]	TOTAL	Yearly % Change
			CHIP		Medicaid Expansion Parents					
2000	Jun-00	154,112	6,042	3,480	-	-	-	-	163,634	
2001	Jun-01	160,374	6,407	3,664	9,562	-	-	-	180,007	10.01%
2002	Jun-02	173,613	9,029	4,130	14,052	-	-	-	200,824	11.56%
2003	Jun-03	195,499	7,943	4,720	14,400	-	15,007		237,569	18.30%
2004	Jun-04	202,923	9,483	4,484	16,681	-	20,901		254,472	7.11%
2005	Jun-05	210,096	10,047	3,942	18,354	1,631	20,556	8,524	273,150	7.34%
2006	Jun-06	213,643	10,270	4,509	18,876	5,108	10,795	14,282	277,483	1.59%
2007	Jun-07	216,185	10,087	4,543	19,325	5,596	20,852	30,461	307,049	10.66%
2008	Jun-08	216,912	9,278	4,561	18,013	5,610	13,954	33,082	301,410	-1.84%
2009	Jun-09	225,693	9,447	4,741	18,900	5,832	11,638	37,302	313,553	4.03%
2010	Jun-10	236,604	10,279	5,200	21,108	6,613	15,397	40,380	335,581	7.03%
2011	Jun-11	244,934	10,131	5,615	21,724	7,700	16,631	43,244	349,979	4.29%
2012	Jun-12	241,404	10,219	5,619	21,020	6,827	13,029	44,313	342,431	-2.16%

56.64%	69.13%	61.47%			When Compared to the total at the end of SFY 2012
50.53%	59.50%	53.36%	119.83%		Since 2000 Membership has increased by 109.27%
39.05%	13.18%	36.05%	49.59%		Since 2001 Membership has increased by 90.23%
23.48%	28.65%	19.05%	45.97%		Since 2002 Membership has increased by 70.51%
18.96%	7.76%	25.31%	26.01%		Since 2003 Membership has increased by 44.14%
14.90%	1.71%	42.54%	14.53%	318.58%	Since 2004 Membership has increased by 34.57%
12.99%	-0.50%	24.62%	11.36%	33.65%	Since 2005 Membership has increased by 25.36%
11.67%	1.31%	23.68%	8.77%	22.00%	Since 2006 Membership has increased by 23.41%
11.29%	10.14%	23.20%	16.69%	21.69%	Since 2007 Membership has increased by 11.52%
6.96%	8.17%	18.52%	11.22%	17.06%	Since 2008 Membership has increased by 13.61%
2.03%	-0.58%	8.06%	-0.42%	3.24%	Since 2009 Membership has increased by 9.21%
-1.44%	0.87%	0.07%	-3.24%	-11.34%	Since 2010 Membership has increased by 2.04%
					Since 2011 Membership has increased by -2.16%